

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Cosentyx[®] SQ (secukinumab) (self-administered) (Pharmacy)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

**Cosentyx[®] is available under both Medical and Pharmacy benefits
(Please select correct PA form)**

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Active Ankylosing Spondylitis	<ul style="list-style-type: none">Five syringes/pens in the initial 28 daysOne syringe/pen per 28 days after induction period. If patient continues to be symptomatic on above may increase to two syringes/pens per 28 days.
<input type="checkbox"/> Active Non-Radiographic Axial Spondyloarthritis (nr-axSpA) – with objective signs of inflammation	<ul style="list-style-type: none">Four syringes/pens in the initial 28 daysOne syringe/pen per 28 days after induction period or one syringe/pen per 28 days without induction
<input type="checkbox"/> Active Psoriatic Arthritis	<ul style="list-style-type: none">Five syringes/pens in the initial 28 daysOne syringe/pen per 28 days after induction period

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DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Active Enthesitis-related arthritis (ERA)	<ul style="list-style-type: none"> Weeks 0, 1, 2, 3, and every 4 weeks thereafter. Weight \geq 15 kg and < 50 kg the dose is 75 mg. Weight \geq 50 kg the dose is 150 mg
<input type="checkbox"/> Moderate to Severe Chronic Plaque Psoriasis	<ul style="list-style-type: none"> Ten syringes/pens in the initial 28 days Two syringes/pens per 28 days after induction period <p>Pediatric:</p> <ul style="list-style-type: none"> < 50kg: Five pediatric 75mg syringes in initial 28 days. One syringe per 28 days after induction period >50kg: Five pediatric 75mg syringes in initial 28 days. Two syringes per 28 days after induction period
<input type="checkbox"/> Moderate to Severe Hidradenitis Suppurative (HS)	<ul style="list-style-type: none"> 300 mg at weeks 0, 1, 2, 3, 4 and every 4 weeks thereafter. Dose may be increased to 300mg every 2 weeks if patient does not adequately respond

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

☐ **Diagnosis: Active Ankylosing Spondylitis**

- ☐ Member is 18 years of age or older
- ☐ Trial and failure of **TWO (2)** of the preferred drugs below (**check each tried**):

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Infliximab
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☐ **Diagnosis: Active Psoriatic Arthritis**

- ☐ Member is 2 years of age or older
- ☐ Trial and failure of **TWO (2)** of the preferred drugs below (**check each tried**):

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Infliximab
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☐ **Diagnosis: Moderate to Severe Chronic Plaque Psoriasis**

- ☐ Member is 6 years of age or older
- ☐ Member has a diagnosis of moderate to severe plaque psoriasis who is a candidate for systemic or phototherapy

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- ☐ Member must have a previous failure on a topical psoriasis agent
- ☐ Trial and failure of **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Infliximab
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☐ **Diagnosis: Non-Radiographic Axial Spondyloarthritis**

- ☐ Member is 18 years of age or older
- ☐ Member has a diagnosis of Active Non-radiographic Axial Spondylarthritis (nr-axSpA) with objective signs of inflammation

☐ **Diagnosis: Active Enthesitis-related arthritis (ERA)**

- ☐ Member is 4 years of age or older
- ☐ Member has a diagnosis of active Enthesitis-Related Arthritis
- ☐ Trial and failure of at least **two (2)** NSAIDs **OR**
- ☐ Use of NSAIDs is contraindicated in patient
- ☐ Trial and failure of **TWO (2)** of the preferred drugs below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®
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☐ **Diagnosis: Hidradenitis Suppurativa (HS)**

- ☐ Member is at least 18 years old
- ☐ Member has a diagnosis of moderate to severe Hidradenitis Suppurativa
- ☐ Trial and failure of Humira®

Medication being provided by Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****