

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 days One 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 days One 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 days One syringe/pen per 28 days after induction period

(Continued on next page)

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><u>Pediatric:</u></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 **BOTH** of the preferred drugs below (**check each tried**):

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]
---	--

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"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
---	--	---

(Continued on next page)

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

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	❑ Enbrel [®]	❑ Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
---	-----------------------	---

❑ 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 **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	❑ Enbrel [®]
---	-----------------------

❑ Diagnosis: Hidradenitis Suppurativa (HS)

- ❑ Member is at least 12 years old
- ❑ Member has a diagnosis of moderate to severe Hidradenitis Suppurativa
- ❑ Trial and failure of adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima[®] (adalimumab-bwwd)

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.****