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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

DIAGNOSIS	Recommended Dose
❑ **Active Ankylosing Spondylitis**	• 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.
❑ **Active Non-Radiographic Axial Spondyloarthritis (nr-axSpA) – with objective signs of inflammation**	• 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
❑ **Active Psoriatic Arthritis**	• Five syringes/pens in the initial 28 days • One syringe/pen per 28 days after induction period
❑ **Active Enthesitis-related arthritis (ERA)**	• Weeks 0, 1, 2, 3, and every 4 weeks thereafter. • Weight ≥ 15 kg and < 50 kg the dose is 75 mg. • Weight ≥ 50 kg the dose is 150 mg

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DIAGNOSIS	Recommended Dose
❑ **Moderate to Severe Chronic Plaque Psoriasis**	• Ten syringes/pens in the initial 28 days • Two syringes/pens per 28 days after induction period **Pediatric**: • < 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

CLINCIAL 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.

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

❑ **Diagnosis: Active Ankylosing Spondylitis**

❑ Trial and failure of at least **two (2)** NSAIDs

OR

❑ Use of NSAIDs is contraindicated in patient

AND

❑ Trial and failure of methotrexate

OR

❑ Medication requested will be used in conjunction with methotrexate

OR

❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below **(check each tried)**:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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❑ Diagnosis: Active Psoriatic Arthritis

- ❑ Trial and failure of methotrexate

OR

- ❑ Medication requested will be used in conjunction with methotrexate

OR

- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below **(check each tried):**

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

- ❑ Member is at least 6 years old and has a diagnosis of moderate to severe plaque psoriasis who is a candidate for systemic or phototherapy

AND

- ❑ Have not responded adequately to a trial of topical agents (e.g., anthralin, coal tar preparations, corticosteroids, emollients, immunosuppressives, keratolytics, retinoic acid derivatives, and/or Vitamin D analogues)

AND

- ❑ Have not responded adequately~~)~~ to a trial of phototherapy (e.g. Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol)

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Non-Radiographic Axial Spondyloarthritis

- ❑ Member has a diagnosis of Active Non-radiographic Axial Spondylarthritis (nr-axSpA) with objective signs of inflammation.

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❑ Diagnosis: Active Enthesitis-related arthritis (ERA)

- ❑ Member is at least 4 years old and has a diagnosis of active Enthesitis-Related Arthritis

AND

- ❑ Trial and failure of at least **two (2)** NSAIDs

OR

- ❑ Use of NSAIDs is contraindicated in patient

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®

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.