SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL 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 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Cosentyx® (secukinumab) **IV (J3247) (Medical)**

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:** _____

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

- Cosentyx 125 mg/5mL solution; 1ml vial and 5ml vial = 125 billable units

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

DIAGNOSIS	Recommended Dose
❑ **Active Ankylosing Spondylitis** ❑ **Active Non-Radiographic Axial Spondyloarthritis (nr-axSpA) – with objective signs of inflammation** ❑ **Active Psoriatic Arthritis**	• **With a loading dosage:** 6 mg/kg given at Week 0 as a loading dose, followed by 1.75 mg/kg every 4 weeks thereafter (max. maintenance dose 300 mg per infusion) • **Without a loading dosage:** 1.75 mg/kg every 4 weeks (max. maintenance dose 300 mg per infusion)

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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
- ❑ Member has a diagnosis of active ankylosing spondylitis
- ❑ Trial and failure of **BOTH** of the preferred drugs below **(check each tried)**:

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

❑ 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 Psoriatic Arthritis

- ❑ Member is 2 years of age or older
- ❑ Member has a diagnosis of active psoriatic arthritis
- ❑ Trial and failure of **TWO (2)** of the preferred drugs below **(check each tried):**

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

Medication being provided by: Please check applicable box below.

❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

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.

***Approved by Pharmacy & Therapeutics Committee:** 1/18/2024
REVISED/UPDATED/REFORMATTED: ~~2/9/2024; 6/10/2024; 10/17/2025, 12/12/2025;~~ **1/20/2026**