pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

COSENTYX (secukinumab) (preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Cosentyx 300 mg dose - 2 pens ☐Cosentyx 300 mg dose - 2 syringes ☐Cosentyx _____

Dose/directions:		Quantity:	Refills:
Beneficiary weight:	Diagnosis *(submit documentation)*:	Dx code (*required*):	

Specialty Pharmacy Drug Program: Which Specialty Pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

Initial requests - complete sections applicable to beneficiary's diagnosis		
1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐up-to-date with all age-appropriate immunizations ☐screened for hepatitis B (surface antigen & core antibody) ☐screened for tuberculosis		
2. ***All diagnoses*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred agent, **Humira**?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
3. ***Ankylosing spondylitis or psoriatic arthritis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Plaque psoriasis*:** Does at least one of of the following apply to the beneficiary? ☐at least 5% of the body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles of feet, and/or genitals)	☐Yes ☐No	*Submit documentation.*
5. ***Plaque psoriasis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of a 3-month trial of phototherapy? *Check all that apply.* ☐PUVA ☐UVB light ☐other: _____	☐Yes ☐No	*Submit documentation of all treatments tried and outcomes.*
6. ***Plaque psoriasis*:** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.* ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
RENEWAL requests		
1. Since starting Cosentyx, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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