COSENTYX (SECUKINUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PerformRx[SM] Next Generation Pharmacy Benefits

Fax to PerformRx[SM] at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION		
☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION		
Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION		
Product requested: ☐ Cosentyx 300 mg dose - 2 pens ☐ Cosentyx 300 mg dose - 2 syringes ☐ Cosentyx ___		
Dose/directions:		
Quantity:	Refills:	Patient weight:
Diagnosis *(submit documentation)*:		Dx code *(required)*:

PHARMACY INFORMATION (PRESCRIBER TO IDENTIFY THE PHARMACY THAT IS TO DISPENSE THE MEDICATION)**:**

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS - COMPLETE SECTIONS APPLICABLE TO PATIENT'S DIAGNOSIS

1. ***All diagnoses:*** Check all that apply to the patient and submit documentation for each.
   ☐ vaccinated for hepatitis B ☐ screened for hepatitis B (surface antigen and core antibody) ☐ up-to-date with all age-appropriate immunizations ☐ screened for tuberculosis

2. ***All diagnoses:*** Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred agent, **Humira**?
   ☐ Yes ☐ No *Submit documentation of clinical response.*

3. ***Ankylosing spondylitis or psoriatic arthritis:*** Does the patient 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 – List medications tried:___ ☐ No

4. ***Plaque psoriasis:*** Does at least one of the following apply to the patient?
   ☐ 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 of clinical response.*

5. ***Plaque psoriasis***: Does the patient 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 patient have a history of trial and failure, contraindication, or intolerance of the following medications? Check all that apply.
   ☐ acitretin ☐ cyclosporine ☐ methotrexate
   ☐ Yes – List medications tried:___ ☐ No

RENEWAL REQUESTS

1. Since starting Cosentyx, did the patient 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

Prescriber signature:	Date:

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