



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Cosentyx (secukinumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

Form with fields for Patient Name, Member/Subscriber Number, Date of Birth, Group Number, Address, City, State ZIP, Primary Phone, Prescriber Name, Supervising Physician, Fax, Office Contact, NPI, Address, City, State ZIP, Specialty/facility name, Phone, State Lic ID.

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?
Q2. Please provide ICD code for diagnosis.
Q3. Please indicate location of administration.
Q4. Is the patient a NEW START to the requested medication?
Q5. Is the prescriber a Dermatologist?



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<b>Patient Name:</b>	<b>Prescriber Name:</b>
	<b>Supervising Physician:</b>
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Is the prescriber a Rheumatologist?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. If requested indication is plaque psoriasis, does the patient have moderate to severe plaque psoriasis affecting greater than 5% of body surface area (BSA)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. If request is for plaque psoriasis, does the patient have moderate to severe plaque psoriasis affecting crucial body areas such as hands, feet, face, or genitals?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. If request is for plaque psoriasis, has the patient failed at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. If request is for plaque psoriasis, has the patient failed or does the patient have a contraindication to phototherapy (UVB or PUVA)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q11. If request is for plaque psoriasis, has the patient failed or does the patient have a contraindication to methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine, OR tacrolimus?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q12. If request is for psoriatic arthritis or ankylosing spondylitis, does patient have documented spinal involvement?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q13. If request is for psoriatic arthritis, has patient failed methotrexate (MTX)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. If request is for psoriatic arthritis, does the patient have a contraindication to methotrexate (MTX)?	
<input type="checkbox"/> Yes (Please specify)	
<input type="checkbox"/> No	
Q15. If patient has a contraindication to methotrexate, has patient failed at least one other DMARD (hydroxychloroquine, sulfasalazine, leflunomide, azathioprine, D-penicillamine, gold, minocycline, cyclosporine)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No



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Q16. If request is for ankylosing spondylitis, has patient failed or does the patient have a contraindication to NSAIDs?
Q17. Has the patient failed Enbrel and Humira? (Please Specify which agents patient has failed)
Q18. Additional comments

Prescriber Signature Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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