PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D 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.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

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)?

- ☐ Moderate to Severe Plaque Psoriasis
- ☐ Active Psoriatic Arthritis
- ☐ Active Ankylosing Spondylitis
- ☐ Other

Q2. Please provide ICD code for diagnosis.

Q3. Is the prescriber a Dermatologist or Rheumatologist?

☐ Yes ☐ No

Q4. Is the patient a new start to therapy?

☐ Yes ☐ No - please specify start date

Q5. Does the patient have trial and failure, contraindication, or intolerance to any of the following? Please select all that apply.

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D 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.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Enbrel
☐ Humira
☐ Other (please specify)

Q6. Is the patient receiving Cosentyx in combination with a biologic DMARD (ex. Enbrel, Humira, Cimzia, Simponi)?

☐ Yes ☐ No

Q7. 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.