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.**

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)?

- ☐ Ankylosing Spondylitis
- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Other

Q2. Please provide ICD code for diagnosis.

Q3. What are the quantity and days supply requested?

Q4. Is the patient a NEW START to the requested medication?

☐ Yes ☐ No (provide start date)

Q5. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q6. Is the prescriber a Rheumatologist?

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☐ Yes ☐ 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)?

☐ Yes ☐ 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?

☐ Yes ☐ No

Q9. If request is for plaque psoriasis, has the patient failed an adequate trial of at least TWO TOPICAL treatments [including but not limited to corticosteroids, Vitamin D analogues, Vitamin D analogue/corticosteroid combinations, Tazorac® (tazarotene)]?

☐ Yes ☐ No

Q10. If request is for plaque psoriasis, has the patient failed an adequate trial of or does the patient have a contraindication to phototherapy (UVB or PUVA)?

☐ Yes ☐ No

Q11. If request is for plaque psoriasis, does the patient have failure of an adequate trial to one of the following? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine
- ☐ tacrolimus

Q12. If request is for plaque psoriasis, does the patient have contraindication to the following? Please select all that apply.

- ☐ methotrexate
- ☐ cyclosporine
- ☐ acitretin
- ☐ leflunomide
- ☐ sulfasalazine

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☐ tacrolimus

Q13. If request is for psoriatic arthritis or ankylosing spondylitis, does patient have documented spinal involvement?

☐ Yes ☐ No

Q14. If request is for psoriatic arthritis, has patient failed an adequate trial of or have clinically significant intolerance to methotrexate (MTX)?

☐ Yes ☐ No

Q15. If request is for psoriatic arthritis, does the patient have a contraindication to methotrexate (MTX)?

☐ Yes (Please specify) ☐ No

Q16. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have failure of an adequate trial to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q17. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have contraindication to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q18. If request is for ankylosing spondylitis, has patient failed an adequate trial of one or does the patient have a contraindication to NSAIDs?

☐ Yes (Please list NSAIDS tried) ☐ No

Q19. Does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to the following preferred biologics? (Please Specify which agents patient has failed)

☐ No
☐ Enbrel
☐ Humira
☐ Tremfya
☐ Other - please specify

Q20. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber

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☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q21. Provide name and NPI of the billing entity

Q22. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q23. 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.