Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Cosentyx (secukinumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Cosentyx (secukinumab).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

Clinical Criteria:

1. Does the member have diagnosis of one of the following? **AND**
   - □ Psoriatic arthritis (PsA)
   - □ Ankylosing Spondylitis (AS)
   - □ Plaque Psoriasis (PsO)

□ Axial Non-Radiographic Spondyloarthritis (nrAxSpA)

□ Active Enthesitis-related arthritis (ERA) (ages ≥ 4 years old)

□ Other: _____

2. Was there therapeutic failure on oral methotrexate? **AND**
   □ No □ Yes

3. Was there therapeutic failure to one of the preferred agents? (e.g. Enbrel, Humira) **AND**
   □ No □ Yes

4. If this is being used for Plaque Psoriasis:
   a. Was there therapeutic failure on a topical psoriasis agent?
      □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**