



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.  
Cosentyx (secukinumab) Prior Authorization (PA)  
Pharmacy Benefits Prior Authorization Help Desk  
Length of Authorizations: Initial- 6 months; Continuation- 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**

Is the prescriber a Rheumatologist or Dermatologist?  No  Yes

If consulted with a specialist, specialist name and specialty: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ 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**

1. Is this request for initial or continuing therapy?

Initial therapy  Continuing therapy, State start date: \_\_\_\_\_

2. Indicate the patient’s diagnosis for the requested medication: \_\_\_\_\_

**Clinical Criteria:**

**Rheumatology:**

**If treating psoriatic arthritis:**

1. Does the patient have a diagnosis of psoriatic arthritis?  
 No  Yes
2. Does the patient have a history of inadequate response after at least a 3-month trial, contraindication, or intolerance to at least ONE of the conventional DMARDs (e.g. methotrexate or leflunomide)?  
 No  Yes
3. Has the patient had an inadequate response, intolerance, or contraindication to adalimumab product [Amjevita (preferred), Humira]?  
 No  Yes

**If treating spondylarthritis:**

1. Has the patient had an inadequate response, contraindication, or intolerance to infliximab product (Inflectra preferred) or adalimumab product (Amjevita preferred)?  
 No  Yes
2. Does the patient meet at least ONE of the following conditions?
  - Diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis, AND has had inadequate response, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis for at least 4 weeks
  - Presence of enthesitis/tendinitis as part of manifestation of peripheral spondyloarthritis such as Achilles tendinopathy or plantar fasciitis
  - Diagnosis of peripheral spondyloarthritis (i.e. reactive arthritis, spondyloarthritis related to inflammatory bowel disease or other peripheral spondyloarthritis rather than axial), does NOT have enthesitis, AND has had inadequate response after a 3-month trial, contraindication, or intolerance to at least one nonbiologic DMARD such as sulfasalazine, methotrexate, or leflunomide No  Yes

**Dermatology:**

**If treating hidradenitis suppurativa:**

1. Does the patient have a diagnosis of moderate-to-severe hidradenitis suppurativa?  
 No  Yes
2. Has the patient had an inadequate response, contraindication, or intolerance to at least THREE of the following therapies? (*Note: Significantly severe hidradenitis suppurativa may proceed with preferred TNF without trial of topical/oral antibiotics or intralesional corticosteroids*)
  - Topical clindamycin 1% solution/lotion/gel (minimum of 12 weeks)
  - Intralesional corticosteroids
  - Oral antibiotics (e.g., doxycycline, tetracycline, clindamycin +/- rifampin, erythromycin) (minimum of 10 weeks)
  - Adalimumab product (Amjevita preferred) or infliximab product (Inflectra preferred) (minimum of 12 weeks) No  Yes

**If treating plaque psoriasis:**

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe)?  
 No  Yes

2. Has the patient had an inadequate response to at least a 3-month trial, contraindication or intolerance to phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)?  
 No  Yes

3. Has the patient had an inadequate response to at least a 3-month trial of at least ONE of the following unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease)?

- Methotrexate
- Acitretin

No  Yes

4. Has the patient had an inadequate response (at least 3-month trial), intolerance, or contraindication to at least one of the preferred anti-TNF agents [i.e. adalimumab-atto (Amjevita) or infliximab-dyyb (Inflectra)]  
 No  Yes

**For continuation of therapy, please respond to additional questions below:**

1. Has the patient had a clinically significant benefit from medication?  
 No  Yes

2. Has specialist follow-up occurred in past 12 months since last review?  
 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:**

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

<b>Provider Signature:</b>	<b>Date:</b>
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