AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Cosentyx® (secukinumab) IV (C9166) (Medical)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

Recommended Dosing: (select **ONE** of the following)

- ❑ Prescribed with a loading dose
- ❑ Prescribed without a loading dose

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing:

- ❑ **With a loading dose:** 6 mg/kg given at Week 0 as a loading dose, followed by 1.75 mg/kg every 4 weeks thereafter (max. maintenance dose 300 mg per infusion).
- ❑ **Without a loading dose:** 1.75 mg/kg every 4 weeks (max. maintenance dose 300 mg per infusion)

- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes and/or pharmacy paid claims)**:

❑ adalimumab product: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®	❑ Rinvoq®
❑ Taltz®	❑ Xeljanz®/XR®	

  - ❑ Member has been established on Cosentyx® IV for at least 90 days as evidenced by medical claims history

❑ Diagnosis: Active Non-Radiographic Axial Spondyloarthritis

Dosing:

- ❑ **With a loading dose:** 6 mg/kg given at Week 0 as a loading dose, followed by 1.75 mg/kg every 4 weeks thereafter (max. maintenance dose 300 mg per infusion)
- ❑ **Without a loading dose:** 1.75 mg/kg every 4 weeks (max. maintenance dose 300 mg per infusion)

- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of active **non-radiographic axial spondyloarthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has at least **ONE** of the following objective signs of inflammation:
  - ❑ C-reactive protein [CRP] levels above the upper limit of normal
  - ❑ Sacroiliitis on magnetic resonance imaging [MRI] (indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs **(verified by chart notes and/or pharmacy paid claims)**

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- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the following **(verified by chart notes and/or pharmacy paid claims)**:

❑ Cimzia® SQ	❑ Rinvoq®	❑ Taltz®

  - ❑ Member has been established on Cosentyx® IV for at least 90 days as evidenced by medical claims history

❑ Diagnosis: Active Psoriatic Arthritis

Dosing:

- ❑ **With a loading dose:** 6 mg/kg given at Week 0 as a loading dose, followed by 1.75 mg/kg every 4 weeks thereafter (max. maintenance dose 300 mg per infusion)
- ❑ **Without a loading dose:** 1.75 mg/kg every 4 weeks (max. maintenance dose 300 mg per infusion)

- ❑ Member is ≥ 18 years of age
- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist or Dermatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine
- ❑ Member meets **ONE** of the following:
  - ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** of the **PREFERRED** biologics below **(verified by chart notes or pharmacy paid claims)**:

❑ adalimumab product: Humira®, Cyltezo® or Hyrimoz®	❑ Enbrel®	❑ Otezla®	❑ Rinvoq®
	❑ Skyrizi®	❑ Stelara®	❑ Taltz®
	❑ Tremfya®	❑ Xeljanz®/XR®	

  - ❑ Member has been established on Cosentyx® IV for at least 90 days as evidenced by medical claims history

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy & Therapeutics Committee:** 1/18/2024
REVISED/UPDATED/REFORMATTED: ~~2/16/2024;~~ **4/4/2024**