

Generic Name: Secukinumab**Therapeutic Class or Brand Name:** Cosentyx®**Applicable Drugs (if Therapeutic Class):** N/A**GPI Code:** 9025057500**Preferred:** N/A**Non-preferred:** N/A**Date of Origin:** 8/25/2016**Date Last Reviewed / Revised:** 8/21/2018

PRIOR AUTHORIZATION CRITERIA

(May be considered medically necessary when criteria I through V are met)

- I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:
 - A. Moderate to severe plaque psoriasis and criteria 1 through 3 are met:
 1. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.
 2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
 3. Diagnosis must be established by a dermatologist or a rheumatologist.
 - B. Active Psoriatic Arthritis and criterion 1 is met:
 1. Diagnosis must be established by a rheumatologist or dermatologist.
 - C. Active Ankylosing Spondylitis and criterion 1 is met:
 1. Diagnosis must be established by a rheumatologist.
- II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).
- III. Minimum age requirement: 18 years old.
- IV. Absence of active serious infection or sepsis.
- V. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

EXCLUSION CRITERIA

- Coadministration of Cosentyx® with another biologic DMARD, Otezla® (apremilast), or Xeljanz®/XR (tofacitinib). Examples of biologic DMARDs include the following:
 - Actemra® (tocilizumab)

- Entyvio® (vedolizumab)
- Kevzara® (sarilumab)
- Kineret® (anakinra)
- Orencia® (abatacept)
- Rituxan® (rituximab)
- Siliq™ (brodalumab)
- Stelara® (ustekinumab)
- Taltz® (Ixekizumab)
- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis™ (infliximab-abda), Simponi®/Simponi® Aria® (golimumab)]
- Tremfya™ (guselkumab)
- Tysabri® (natalizumab)

OTHER CRITERIA

- N/A

QUANTITY / DAYS SUPPLY RESTRICTIONS

- Plaque Psoriasis:
 - Quantities of up to 10 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Psoriatic Arthritis:
 - Quantities of up to 5 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Ankylosing Spondylitis:
 - Quantities of up to 5 syringes or pens for the first 28 days, then 1 syringe or pen every 28 days thereafter.

APPROVAL LENGTH

- **Authorization:** 1 year

- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

APPENDIX

N/A

REFERENCES

1. <https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/cosentyx.pdf>.
2. Medi-Span

HISTORICAL TRACKING OF CHANGES MADE TO POLICY

Date	Notes/Changes
8/21/2018	1. No changes
11/21/2017	2. Added "Kevzara® (sarilumab)", "Siliq™ (brodalumab)", and "Tremfya™ (guselkumab)" to list under Exclusion Criteria. 3. Added "Inflectra® (infliximab-dyyb)" and "Renflexis™ (infliximab-abda)" following TNF Inhibitors to list under Exclusion Criteria.
12/2/2016	1. Changed "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" to "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" under Prior Authorization Criteria. 2. Changed "II. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)" to "II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)" under Prior Authorization Criteria.
Click or tap to enter a date.	1. 2.