TRICARE Prior Authorization Request Form for
secukinumab **(Cosentyx )**

JOHNS HOPKINS
HEALTH PLANS
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**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1**

**Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

**Step 2**

**Please complete clinical assessment:**

| | | |
|---|---|---|
| **1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>Proceed to question **4** |
| **2. Has the patient had an inadequate response to Humira?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>Proceed to question **3** |
| **3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have a contraindication to Humira (adalimumab)?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>Proceed to question **7** |

**6. What is the indication or diagnosis for this adult patient?**

- ☐ Active psoriatic arthritis (PsA) – Proceed to question **11**
- ☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **11**
- ☐ Active ankylosing spondylitis (AS) – Proceed to question **12**
- ☐ Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation – Proceed to question **12**
- ☐ Moderate to severe hidradenitis suppurativa (HS) – Proceed to question **11**
- ☐ Other indication or diagnosis – **STOP: coverage not approved.**

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| | | |
|---|---|---|
| **7. What is the indication or diagnosis for this pediatric patient?** | ☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **8**<br>☐ Active enthesitis-related arthritis (ERA) – Proceed to question **9**<br>☐ Active psoriatic arthritis (PsA) – Proceed to question **10**<br>☐ Other indication or diagnosis – **STOP: coverage not approved** | |
| **8. How old is the patient?** | ☐ Greater than or equal to 6 years of age and Less than or equal to 17 years of age - Proceed to question **11**<br>☐ Other – **STOP Coverage not approved** | |
| **9. How old is the patient?** | ☐ Greater than or equal to 4 years of age and Less than or equal to 17 years of age - Proceed to question **13**<br>☐ Other – **STOP Coverage not approved** | |
| **10. How old is the patient?** | ☐ Greater than or equal to 2 years of age and Less than or equal to 17 years of age -Proceed to question **11**<br>☐ Other – **STOP Coverage not approved** | |
| **11. Has the patient had an inadequate response to non-biologic systemic therapy? For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], antibiotics, anti-androgens, etc.** | ☐ Yes<br>Proceed to question **13** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **12. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?** | ☐ Yes<br>Proceed to question **13** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **13. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?** | ☐ Yes<br>Proceed to question **14** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **14. Will the patient be receiving other targeted immunomodulatory biologics with Cosentyx, including but not limited to the following: Actemra, Cimzia, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rinvoq ER, Rituxan, Siliq, Simponi, Skyrizi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**Sign and date below.** |

**Step 3**

**I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[02 Oct 2024]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |