aetna®

# Cosentyx® (secukinumab) Injectable Medication Precertification Request



(All fields must be completed and legible for Precertification Review.)

**Aetna Precertification Notification**
**Phone:** 1-855-240-0535
**FAX:** 1-877-269-9916

**For Medicare Advantage Part B:**
FAX: 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | Email: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one):* ☐ Dermatologist ☐ Rheumatologist ☐ Immunologist ☐ Other: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Cosentyx: Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For initiation requests (clinical documentation required):**

☐ Yes ☐ No Will secukinumab (Cosentyx) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the date and results of the TB test: Date: ____/____/____ Results: ☐ Positive ☐ Negative ☐ Unknown
***If positive,*** Does the patient have latent or active TB? ☐ Latent ☐ Active
***If latent TB,*** ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with secukinumab (Cosentyx)?

**Ankylosing Spondylitis:**

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Has the patient had an inadequate response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and date ranges: NSAID #1: _____ Date range: ____/____/____ to ____/____/____
NSAID #2: _____ Date range: ____/____/____ to ____/____/____

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION *(continued)*** – Required clinical information must be completed in its entirety for all precertification requests.

**Plaque Psoriasis:**

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is there clinical documentation of chronic disease?

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Is the patient a candidate for systemic treatment with conventional DMARD(s)?

→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

Provide the name and date range: Name: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?

☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

☐ Yes ☐ No Is the patient a candidate for phototherapy?

→ ☐ Yes ☐ No Was the trial with phototherapy ineffective?

Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)
☐ UVB with coal tar or dithranol
☐ UVB (standard or narrow-band)
☐ Home UVB

Date range of phototherapy use: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the trial with phototherapy not tolerated?

☐ Yes ☐ No Is phototherapy contraindicated?

**Psoriatic Arthritis:**

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Provide the names and date ranges: NSAID #1: _____ Date range: ____/____/____ to ____/____/____

NSAID #2: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective? ***If yes***, Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the treatment with methotrexate not tolerated or contraindicated? ☐ not tolerated ☐ contraindicated

→ ☐ Yes ☐ No Was a trial with at least 1 conventional disease-modifying anti-rheumatic drug (DMARD) (other than methotrexate) ineffective?

Name: _____ Date range: ____/____/____ to ____/____/____

**For Continuation of Therapy:**

Please indicate the length of time on secukinumab (Cosentyx): _____

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of secukinumab (Cosentyx)? (Sampling of secukinumab (Cosentyx) does not guarantee coverage under the provisions of the pharmacy benefit).

☐ Yes ☐ No Will secukinumab (Cosentyx) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

☐ Yes ☐ No Is there clinical documentation supporting disease stability?

☐ Yes ☐ No Is there clinical documentation supporting disease improvement?

☐ Yes ☐ No Does the patient have any risk factors for TB?

→ ☐ Yes ☐ No Has the patient had a TB test within the past year?

→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

Please enter the date and results of the TB test: Date: ____/____/____

Results: ☐ Positive ☐ Negative ☐ Unknown

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.