Prescriber Criteria Form Cosentyx 2025 PA Fax 1237-A v5 030125.docx Cosentyx (secukinumab) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Cosentyx (secukinumab).

Drug Name: Cosentyx (secukinumab)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) plaque psoriasis, B) psoriatic arthritis, C) ankylosing spondylitis, D) non-radiographic axial spondyloarthritis, E) hidradenitis suppurativa? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 5.]	Yes ◯	No ◯
3	Does the patient meet one of the following criteria: A) at least 3 percent of body surface area (BSA) was affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, scalp, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) adalimumab-aacf, B) Enbrel (etanercept), C) Humira (adalimumab), D) Idacio (adalimumab-aacf), E) Skyrizi (risankizumab-rzaa), F) Sotyktu (deucravacitinib), G) Stelara (ustekinumab), H) Tremfya (guselkumab)? [No further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of active psoriatic arthritis (PsA)? [If no, then skip to question 8.]	Yes ◯	No ◯

6	Is the request for an adult patient? [If no, then no further questions.]	Yes ◯	No ◯
7	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) adalimumab-aacf, B) Enbrel (etanercept), C) Humira (adalimumab), D) Idacio (adalimumab-aacf), E) Rinvoq (upadacitinib)/Rinvoq LQ (upadacitinib), F) Skyrizi (risankizumab-rzaa), G) Stelara (ustekinumab), H) Tremfya (guselkumab), I) Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release)? [No further questions.]	Yes ◯	No ◯
8	Does the patient have a diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA)? [If no, then skip to question 10.]	Yes ◯	No ◯
9	Does the patient meet either of the following criteria: A) patient has experienced an inadequate treatment response to a non-steroidal anti-inflammatory drug (NSAID), B) patient has experienced an intolerance or has a contraindication that would prohibit a trial of NSAIDs? [No further questions.]	Yes ◯	No ◯
10	Does the patient have a diagnosis of active ankylosing spondylitis? [If no, then skip to question 12.]	Yes ◯	No ◯
11	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) adalimumab-aacf, B) Enbrel (etanercept), C) Humira (adalimumab), D) Idacio (adalimumab-aacf), E) Rinvoq (upadacitinib), F) Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release)? [No further questions.]	Yes ◯	No ◯
12	Does the patient have a diagnosis of active enthesitis-related arthritis (ERA)? [If yes, then no further questions.]	Yes ◯	No ◯
13	Does the patient have a diagnosis of moderate to severe hidradenitis suppurativa (HS)? [If no, then no further questions.]	Yes ◯	No ◯
14	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following products: A) adalimumab-aacf, B) Humira (adalimumab), C) Idacio (adalimumab-aacf)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____