Manual Prior Authorization

MISSISSIPPI DIVISION OF MEDICAID

Secukinumab (Cosentyx®)

PRIOR AUTHORIZATION CRITERIA:
ICD-10 code(s):_____

Requests for secukinumab (Cosentyx®) may be approved if the following criteria are met:
(Yes should be checked for each statement):

☐ Yes ☐ No Age ≥ 18 years

☐ Yes ☐ No Treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy

☐ Yes ☐ No Prescribed by or in consultation with a dermatologist or rheumatologist

☐ Yes ☐ No Inadequate response after minimum 3-month trial, or Intolerance or Contraindication to adalimumab (Humira®)

Initial authorization is for 4 months. Subsequent approval will be based on current progress notes documenting stability of disease status.
Dosing:

- 300mg SC initial dose repeated at weeks 1, 2, 3, and 4 followed by 300mg Q 4 weeks. (may allow up to 10 pens or syringes in the ***first*** 28 days of treatment).
- 150mg may be acceptable for some patients.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Reauthorization: Continued treatment will be approved for up to 6 months

- (Maximum amount approval: 300mg/month)

☐ Yes ☐ No Is there documentation of positive clinical response to therapy? (at least a 50% reduction in disease activity using an objective measurement) –please provide written documentation if requested.

General information to consider:

- Cosentyx may increase the risk of infections. Exercise caution when considering the use of Cosentyx in patients with a chronic infection or a history of recurrent infection.
- Prior to initiating treatment, evaluate for TB. Do not administer Cosentyx to patients with active TB infection. Initiate treatment of latent TB prior to administering Cosentyx.
- Exercise caution when prescribing Cosentyx to patients with active Crohns disease.
- Patients treated with Cosentyx should not receive live vaccines.