# Pharmacy Drug Policy Checklist

| POLICY NAME | Cosentyx (secukinumab) | POLICY # | |
|---|---|---|---|

## Criteria

### Exclusion Criteria – Any of the following prevents coverage

- ☐ **7.1** Inadequate response to initial or previous Cosentyx therapy
- ☐ **7.2** Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure
- ☐ **7.3** Health Alliance does not cover concurrent therapy with other biologic DMARDS or other TNF blockers based upon the possible increased risk for infections and other potential pharmacological interactions

### Coverage Criteria for Plaque Psoriasis

- ☐ **1.1** See Plaque Psoriasis Immunomodulator Therapies policy

### Coverage Criteria for Ankylosing Spondylitis

- ☐ **2.1** See Ankylosing Spondylitis Immunomodulator Therapies policy

### Coverage Criteria for Psoriatic Arthritis

- ☐ **3.1** See Psoriatic Arthritis Immunomodulator Therapies policy

### Coverage Criteria for Nonradiographic Axial Spondyloarthritis

- ☐ **4.1** See Nonradiographic Axial Spondyloarthritis Immunomodulators policy

## Coverage Criteria for enthesitis-related arthritis (ERA)

- ☐ **5.1** Diagnosis of active enthesitis-related arthritis
- ☐ **5.2** Age 4 years of age or older
- ☐ **5.3** Prescribed by or with a rheumatologist (musculoskeletal doctor)
- ☐ **5.4** Trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen)

## Coverage Criteria for Hidradenitis Suppurativa

- ☐ **6.1** See Hidradenitis Suppurativa Immunomodulator Therapies policy

## Approval Time

- ☐ **8.1** Initial: 12 Months
- ☐ **8.2** Reauthorization: 12 months with documentation of clinical benefit CPT Codes HCPCS Codes J3247 Injection, secukinumab, intravenous, 1 mg References