Cosentyx® (secukinumab) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY:711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

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** ☐ **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 ☐ Other: _____
Name: _____
Address: _____
Phone: _____ FAX: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Cosentyx (secukinumab) Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other any other where applicable (*).

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

G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the patient's ability to tolerate a large volume or load or predispose the patient to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

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

Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:

- ☐ latent TB and treatment for latent TB has been initiated
- ☐ latent TB and treatment for latent TB has been completed
- ☐ latent TB and treatment for latent TB has not been initiated
- ☐ active TB

For Initiation Requests (clinical documentation required for all requests):

Ankylosing spondylitis and non-radiographic axial spondyloarthritis

Please indicate loading dose: _____ Please indicate maintenance dose: _____ frequency: _____weeks

Please select which of the following applies to the patient: ☐ Active ankylosing spondylitis (AS) ☐ Active non-radiographic axial spondyloarthritis

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs?

Psoriatic arthritis

Please indicate loading dose:_____ Please indicate maintenance dose: _____frequency: _____weeks

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

☐ Yes ☐ No Has the patient been diagnosed with active psoriatic arthritis (PsA)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) that is indicated for moderately to severely active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)?

→ ☐ Yes ☐ No Does the patient have mild to moderate disease?

→ ☐ Yes ☐ No Does the patient have severe disease?

→ ☐ Yes ☐ No Does the patient have enthesitis or predominantly axial disease?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration?

→ ☐ Yes ☐ No Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)?

→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate or leflunomide?

→ ☐ Yes ☐ No Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)?

Please indicate the contraindication to methotrexate or leflunomide:

- ☐ History of intolerance or adverse event
- ☐ Risk of treatment-related toxicity
- ☐ Hypersensitivity ☐ Breastfeeding
- ☐ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- ☐ Pregnancy or currently planning pregnancy
- ☐ Drug interaction
- ☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
- ☐ Other: _____

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

For Continuation Requests (clinical documentation required for all requests):

Please indicate maintenance dose: _____ frequency: _____weeks

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug?

☐ Yes ☐ No Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose?

Ankylosing spondylitis and non-radiographic axial spondyloarthritis

Please indicate which of the following has the patient experienced:

☐ Functional status ☐ Total spinal pain ☐ Inflammation (e.g., morning stiffness) ☐ None of the above

Psoriatic arthritis

Please indicate which of the following has the patient experienced:

☐ Number of swollen joints ☐ Number of tender joints ☐ Dactylitis ☐ Enthesitis ☐ Axial disease ☐ Skin and/or nail involvement ☐ None of the above

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.