HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
COSENTYX® for Enthesitis-Related Arthritis

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-856-5694

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Cosentyx® (secukinumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
ENTHESITIS-RELATED ARTHRITIS			
1. Does the member have a diagnosis of enthesitis-related arthritis?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a rheumatologist?	☐	☐	**Please provide documentation**
3. Does clinical documentation show an adequate trial and failure, contraindication, or intolerance to at least two nonsteroidal anti-inflammatory drugs (NSAIDs)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	**Please provide documentation**
2. Does clinical documentation show a positive clinical response to therapy as evidenced by at least one of the following: • Reduction in the total active (swollen and tender) joint count from baseline, or • Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM-HU-129
Origination Date: 03/02/2022
Reviewed/Revised Date: 03/16/2022
Next Review Date: 03/16/2023
Current Effective Date: 04/01/2022