MEDICATION POLICY

Generic Name: Secukinumab

Therapeutic Class or Brand Name: Cosentyx®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 8/25/16 **Date Last Reviewed/Revised:** 12/2/16

GPI Code: 9025057500

Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):

I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:
   A. Moderate to severe plaque psoriasis and criteria 1 through 3 are met:
      1. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.
      2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
      3. Diagnosis must be established by a dermatologist or a rheumatologist.
   B. Active Psoriatic Arthritis and criterion 1 is met:
      1. Diagnosis must be established by a rheumatologist or dermatologist.
   C. Active Ankylosing Spondylitis and criterion 1 is met:
      1. Diagnosis must be established by a rheumatologist.

II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).

III. Minimum age requirement: 18 years old.

IV. Absence of active serious infection or sepsis.

V. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

Exclusion Criteria:

- Coadministration of Cosentyx® with another biologic DMARD, Otezla® (apremilast), or Xeljanz®/ XR (tofacitinib). Examples of biologic DMARDs include the following:
  - Actemra® (tocilizumab)

- Entyvio® (vedolizumab)
- Kineret® (anakinra)
- Orencia® (abatacept)
- Rituxan® (rituximab)
- Stelara® (ustekinumab)
- Taltz® (Ixekizumab)
- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Remicade® (infliximab), Simponi®/Simponi® Aria® (golimumab)]
- Tysabri® (natalizumab)

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- Plaque Psoriasis:
  - Quantities of up to 10 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Psoriatic Arthritis:
  - Quantities of up to 5 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Ankylosing Spondylitis:
  - Quantities of up to 5 syringes or pens for the first 28 days, then 1 syringe or pen every 28 days thereafter.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

N/A

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References:

1. https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/cosentyx.pdf.
2. Medi-Span.

MEDICATION POLICY

Historical Tracking Of Changes Made To Policy	
12/2/2016	1. **Changed** "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **to** "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **under Prior Authorization Criteria**. 2. **Changed** "II. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)" **to** "II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)" **under Prior Authorization Criteria**.