Cosentyx® (secukinumab)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)
FAX TO: (858) 790-7100
c/o MedImpact Healthcare Systems, Inc.
Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-844-336-2677

Instructions:
This form is to be used by participating providers to obtain coverage for the drug listed above which requires prior authorization. Please complete this form and fax it to *MedImpact* Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact *MedImpact's* Customer Service at (844) 336-2677.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Cosentyx®**	
Dose, Directions, and Quantity Requested:	
Date Requested:	**Length of Treatment** (*please be specific*)**:**

Documentation of Medical Necessity (please complete all sections that apply):

1. Does the patient have a diagnosis of ***psoriatic arthritis***? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e. is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on this medication? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** of the following DMARD agents?

methotrexate	☐ Yes	☐ No	**If yes**, describe the response/reaction to that medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

AND

Has the patient received a loading dose? ☐ Yes ☐ No If yes, please provide date of loading dose: _____

2. Does the patient have a diagnosis of ***moderate to severe plaque psoriasis***? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, did the patient achieve or maintain clear or minimal disease or experience a decrease in PASI (Psoriasis Area and Severity Index) of at least 50%? ☐ Yes ☐ No

AND

Does the plaque psoriasis involve at least 10% body surface area (BSA) or are there psoriatic lesions affecting the face, hands, feet, or genital area? ☐ Yes ☐ No

AND

Has this medication been prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** of the following preferred therapies?

PUVA (Phototherapy Ultraviolet Light A)	☐ Yes	☐ No	cyclosporine	☐ Yes	☐ No
UVB (Ultraviolet Light B)	☐ Yes	☐ No	methotrexate	☐ Yes	☐ No
topical corticosteroids	☐ Yes	☐ No	calcipotriene	☐ Yes	☐ No
acitretin	☐ Yes	☐ No			

If yes on any of the above, please describe the response/reaction to those treatments: _____

_____

_____

3. Does the patient have a diagnosis of ***ankylosing spondylitis***? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained an improvement of ≥50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)? ☐ Yes ☐ No

AND

Has this medication been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient received a loading dose? ☐ Yes ☐ No If yes, please provide date of loading dose: _____