Pharmacy Medical Necessity Guidelines:
Cosentyx® (secukinumab)

Effective: February 17, 2023

Guideline Type
☒ Prior Authorization
☐ Non-Formulary
☐ Step-Therapy
☐ Administrative

Applies to:

Commercial Products
☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988
☒ Tufts Health Plan Commercial products; Fax: 617-673-0988
  CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products
☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications
Cosentyx (secukinumab) is an interleukin-17A antagonist indicated for:

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<th>Disease State</th>
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<td>Ankylosing Spondylitis</td>
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<tr>
<td>Enthesitis-related Arthritis</td>
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<tr>
<td>Non-radiographic Axial Spondyloarthritis</td>
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<tr>
<td>Plaque Psoriasis</td>
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<tr>
<td>Psoriatic Arthritis</td>
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Clinical Guideline Coverage Criteria

The plan may authorization coverage of Cosentyx for Members when all of the following criteria are met:
Ankylosing Spondylitis
1. Documented diagnosis of ankylosing spondylitis  
2. Patient is at least 18 years of age  
3. Prescribed by or in consultation with a rheumatologist  
4. Documentation of one (1) of the following:  
   a. All of the following:  
      i. One (1) of the following:  
         1. Inadequate response or adverse reaction to one (1), or contraindication to all prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam)  
         2. Previous treatment with a biologic agent indicated for the requested use  
      ii. Trial and failure with two (2), or contraindication to all of the following: Cimzia, Enbrel, Humira, Rinvoq, Simponi, Xeljanz  
      iii. Trial and failure with or contraindication to Taltz  
   b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Enthesitis-related Arthritis
1. Documented diagnosis of enthesitis-related arthritis  
2. Patient is at least 4 years of age  
3. Prescribed by or in consultation with a rheumatologist

Non-radiographical Axial Spondyloarthritis
1. Documented diagnosis of non-radiographic axial spondyloarthritis  
2. Patient is at least 18 years of age  
3. Prescribed by or in consultation with a rheumatologist  
4. Documentation of objective signs of inflammation  
5. Documentation of one (1) of the following:  
   a. Both of the following:  
      i. One (1) of the following:  
         1. Inadequate response or adverse reaction to one (1), or contraindication to all prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam)  
         2. Previous treatment with a biologic agent indicated for the requested use  
      ii. Trial and failure with or contraindication to all of the following: Cimzia, Rinvoq, Taltz  
   b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes
Plaque Psoriasis

1. Documented diagnosis of plaque psoriasis AND

2. Patient is at least 6 years of age AND

3. Prescribed by or in consultation with a dermatologist AND

4. Documentation of one (1) of the following:
   a. All of the following:
      i. One (1) of the following:
         1. Inadequate response to one (1), or contraindication to all of the following topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar
         2. Previous treatment with a biologic agent indicated for the requested use
      ii. Trial and failure with three (3), or contraindication to all of the following: Cimzia, Enbrel, Humira, Skyrizi, Stelara, Tremfya
      iii. Trial and failure with or contraindication to Taltz

   b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Psoriatic Arthritis

1. Documented diagnosis of psoriatic arthritis AND

2. Patient is at least 2 years of age AND

3. Prescribed by or consultation with a rheumatologist or dermatologist AND

4. Documentation of one (1) of the following:
   a. Both of the following:
      i. Trial and failure with two (2), or contraindication to all of the following: Cimzia, Enbrel, Humira, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya, Xeljanz
      ii. Trial and failure with both, or contraindication to Orencia and Taltz
   b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Limitations

1. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response and will not be considered for prior authorization.

2. Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinical inappropriateness to methotrexate therapy.

Codes

None

References

1. Cosentyx (secukinumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; Dec 2021.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.
- February 14, 2023: Included Rinvoq as a prerequisite option for non-radiographic axial spondyloarthritis (effective February 17, 2023)

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member’s health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.