maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Cosentyx

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (for example, Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC), Examples of Targeted Synthetic Disease-Modifying Antirheumatic Drugs include but not limited	Yes	No

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	to Cibinqo, Olumiant, Rinvoq, Otezla, Xeljanz, Xeljanz XR.] [If yes, no further questions.]		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	What is the indication or diagnosis? [] Ankylosing spondylitis (If checked, go to 8) [] Enthesitis-related arthritis (If checked, go to 13.) [] Non-radiographic axial spondyloarthritis (If checked, go to 19) [] Plaque psoriasis (If checked, go to 26) [] Psoriatic arthritis (If checked, go to 33) [] Hidradenitis suppurativa (If checked, go to 41) [] Crohn's disease (If checked, no further questions) [] Rheumatoid arthritis (If checked, no further questions) [] Uveitis (If checked, no further questions) [] All other indications/diagnosis (If checked, no further questions)		
8	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No

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9	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Is the requested medication being prescribed by or in consultation with a rheumatologist**?** [If no, no further questions.]	Yes	No
12	Does the requested dose exceed FDA approved label dosing for the requested indication**?** (Dosing: 150mg at weeks 0, 1, 2, 3, 4 every 4 weeks thereafter or 150mg every 4 weeks) [No further questions.]	Yes	No
13	Is the patient greater than or equal to 4 year(s) of age? [If no, no further questions.]	Yes	No
14	Has the patient tried at least one prescription strength systemic agent for at least 3 months? [Note: Examples of prescription strength systemic agents include NSAIDs such as ibuprofen and naproxen.] [If yes, skip to question 16.]	Yes	No
15	Has documentation been provided to confirm that the patient had an intolerance to at least two prescription strength systemic agents? [Note: Examples of prescription strength systemic agents include NSAIDs such as ibuprofen and naproxen.] [If no, no further questions.]	Yes	No
16	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed FDA approved label dosing for the requested indication?	Yes	No

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	(Dosing: 75mg or 150mg at weeks 0, 1, 2, 3, 4 every 4 weeks thereafter) [No further questions.]		
19	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
20	Does the patient have a documented clinical diagnosis of non-radiographic axial spondyloarthritis? [If no, no further questions.]	Yes	No
21	Does the patient have an objective sign of inflammation defined as a C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 23.]	Yes	No
22	Does the patient have an objective sign of inflammation defined as a sacroiliitis reported on magnetic resonance imaging? [If no, no further questions.]	Yes	No
23	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept), an adalimumab product (Hadlima, Yusimry, or adalimumab-adbm), and Cimzia (certolizumab)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
24	Is the requested medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
25	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 150mg at weeks 0, 1, 2, 3, 4 every 4 weeks thereafter or 150mg every 4 weeks) [No further questions.]	Yes	No
26	Is the patient greater than or equal to 6 year(s) of age? [If no, no further questions.]	Yes	No
27	Has the patient tried at least TWO traditional systemic agent for psoriasis for at least 3 months? [Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, or acitretin tablets.] [If yes, skip to question 29.]	Yes	No
28	Has documentation been provided to confirm that the patient had an intolerance to at least two traditional systemic agents? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[Note: Examples of traditional systemic agents for psoriasis include methotrexate, cyclosporine, or acitretin tablets.] [If no, no further questions.]		
29	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
30	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred Ustekinumab product (Pyzchiva, Steqeyma, or Yesintek), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
31	Is the requested medication being prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
32	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 150mg at weeks 0, 1, 2, 3, 4 every 4 weeks thereafter or 150mg every 4 weeks) [No further questions.]	Yes	No
33	Is the patient greater than or equal to 2 year(s) of age? [If no, no further questions.]	Yes	No
34	Has the patient tried at least TWO conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 36.]	Yes	No
35	Has documentation been provided to confirm that the patient had an intolerance to at least two conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
36	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

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37	Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred Ustekinumab product (Pyzchiva, Steqeyma, or Yesintek), for at least 3 months or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
38	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
39	Is this medication being prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
40	Does the requested dose exceed FDA approved label dosing for the requested indication? [No further questions.]	Yes	No
41	Is the patient greater than or equal to 18 year(s) of age? [If no, no further questions.]	Yes	No
42	Is this medication being prescribed by or in consultation a dermatologist? [If no, no further questions.]	Yes	No
43	Has the patient tried at least ONE other therapy for at least 3 months? [Note: Examples include intralesional or oral corticosteroids (such as triamcinolone, prednisone), systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin), or isotretinoin.] [If no, no further questions.]	Yes	No
44	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitor, adalimumab products? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
45	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 300mg at weeks 0, 1, 2, 3, 4 every 4 weeks)	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250