**Cosentyx® (secukinumab)**

*Effective 01/01/2022*

<table>
<thead>
<tr>
<th>Plan</th>
<th>☐ MassHealth</th>
<th>☒ MassHealth (PUF)</th>
<th>☐ Commercial/Exchange</th>
<th>Program Type</th>
<th>☒ Prior Authorization</th>
<th>☒ Quantity Limit</th>
<th>☐ Step Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
<td>☐ Medical Benefit (NLX)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specialty Limitations**
This medication has been designated specialty and must be filled at a contracted specialty pharmacy.

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Specialty Medications</th>
<th>Non-Specialty Medications</th>
<th>Medical Specialty Medications (NLX)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All Plans</td>
<td>MassHealth</td>
<td>All Plans</td>
</tr>
<tr>
<td></td>
<td>Phone: 866-814-5506</td>
<td>Phone: 877-433-7643</td>
<td>Phone: 844-345-2803</td>
</tr>
<tr>
<td></td>
<td>Fax: 866-249-6155</td>
<td>Fax: 866-255-7569</td>
<td>Fax: 844-851-0882</td>
</tr>
<tr>
<td></td>
<td>Commercial</td>
<td>Phone: 800-294-5979</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone: 855-582-2022</td>
<td>Fax: 855-245-2134</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Exceptions**
N/A

**Overview**
Cosentyx is a human interleukin-17A antagonist indicated for the treatment of:
- Moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy
- Adults with active psoriatic arthritis (PsA)
- Adults with active ankylosing spondylitis (AS)
- Active nonradiographic axial spondyloarthritis in adults with objective signs of inflammation

**Coverage Guidelines**
Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Cosentyx excluding when the product is obtained as samples or via manufacturer’s patient assistance programs.

**OR**
Authorization may be granted for members when ALL the following criteria are met, and documentation is provided:

**Ankylosing spondylitis and Non-radiographic axial spondyloarthritis:**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. Paid claims or physician documented inadequate response or adverse reaction to **TWO** NSAIDs or contraindication to **ALL** NSAIDs
3. **ONE** of the following:
   a. Paid claims or physician attestation of inadequate response or adverse reaction to **ONE** anti-TNF agent that is FDA-approved for the requested indication
b. Contraindication to **ALL** anti-TNF agents that are FDA-approved for the requested indication

4. Appropriate dosing

**Moderate-severe plaque psoriasis:**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. **ONE** of the following:
   a. Paid claims or physician documented inadequate response or adverse reaction to **ONE**
      conventional therapy (see appendix B):
      i. topical agent
      ii. phototherapy
      iii. systemic agent
   b. Contraindication to **ALL conventional therapies**:
      i. topical agent
      ii. phototherapy
      iii. systemic agent
   c. Paid claims or physician documented inadequate response or adverse reaction to **ONE**
      biologic DMARD that is FDA-approved for plaque psoriasis
3. Appropriate dosing
4. Prescriber provides clinical rationale for use of Cosentyx instead of Stelara®

**Psoriatic arthritis:**
Prescriber provides documentation of **ALL** of the following:
1. Appropriate diagnosis
2. **ONE** of the following:
   a. Paid claims or physician documented inadequate response or adverse reaction to **ONE** anti-
      TNF agent that is FDA-approved for the requested indication
   b. Contraindication to **ALL** anti-TNF agents that are FDA-approved for the requested indication
3. Appropriate dosing

**Continuation of Therapy**
Reauthorization requires physician documentation of continuation of therapy, positive response to
therapy, FDA approved indication and appropriate dosing.

**Limitations**
1. Initial approvals will be granted for the following based on diagnosis:
   a. Plaque psoriasis: 3 months
   b. All other diagnosis: 6 months
2. Reauthorizations will be granted for 12 months
3. The following quantity limits apply:

<table>
<thead>
<tr>
<th>Product</th>
<th>Quantity Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosentyx Inj 150mg/mL</td>
<td>150mg (1mL) per 28 days</td>
</tr>
<tr>
<td>Cosentyx Pen Inj 150mg/mL</td>
<td></td>
</tr>
<tr>
<td>Cosentyx Inj 300mg dose</td>
<td>300mg (2mL) per 28 days</td>
</tr>
<tr>
<td>Cosentyx Pen Inj 300mg dose</td>
<td></td>
</tr>
</tbody>
</table>

**Appendices**

**Appendix A: Dosing**
Cosentyx®
(secukinumab)  
| Plaque Psoriasis: |  
| SQ: 300 mg initially at week 0, 1, 2, 3 and 4, followed by 300 mg every 4 weeks  
| Psoriatic Arthritis: |  
| SQ: 150 mg initially at week 0, 1, 2, 3 and 4, followed by 150 mg every 4 weeks, may consider dose of 300 mg if psoriatic arthritis continues  
| Co-existent Plaque Psoriasis AND Psoriatic Arthritis: |  
| SQ: 300 mg initially at week 0, 1, 2, 3 and 4, followed by 300 mg every 4 weeks  
| Ankylosing Spondylitis: |  
| SQ: 150 mg initially at week 0, 1, 2, 3 and 4, followed by 150 mg every 4 weeks, may increase to 300 mg every 4 weeks  

Appendix B. Conventional Therapies for Plaque Psoriasis

<table>
<thead>
<tr>
<th>Conventional Treatment Lines</th>
<th>Agents Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical Agents</td>
<td>emollients, keratolytics, corticosteroids, coal tar, anthralin, calcipotriene, tazarotene, calcitriol, calcineurin inhibitors</td>
</tr>
<tr>
<td>Systemic Agents</td>
<td>Traditional DMARDs: methotrexate, apremilast, acitretin,</td>
</tr>
<tr>
<td>Phototherapy</td>
<td>ultraviolet A and topical psoralens (topical PUVA), ultraviolet A and oral psoralens (systemic PUVA), narrow band UV-B (NUVB)</td>
</tr>
</tbody>
</table>

Appendix C: Off-Label Indications

Hidradenitis Suppurativa (HS)
the prescriber provides documentation of ALL of the following:
1. Diagnosis of moderate to severe hidradenitis suppurativa (Hurley Stage II and Hurley Stage III disease)
2. Paid claims or physician documented inadequate response or adverse reaction to ONE oral antibiotic or contraindication to ALL oral antibiotics (e.g. rifampin, clindamycin, tetracycline, doxycycline, minocycline)
3. Paid claims or physician documented Inadequate response, adverse reaction or contraindication to Humira® (adalimumab) AND Stelara® (ustekinumab)
4. Appropriate dosing: Cosentyx® (secukinumab) 300mg weekly for five weeks then 300 mg every four weeks

More Frequent/High Doses
Requests for more frequent or higher doses of injectable biologics may be approved if ALL of the following is provided:
1. Documentation of severe disease
2. ONE of the following:
   a. Paid claims or physician documented inadequate response or adverse reaction to ONE other injectable biologic which is FDA-approved for the requested indication
   b. Contraindication to ALL other injectable biologics which are FDA-approved for the requested indication
3. Documented partial response to FDA-approved dosing of current biologic therapy
4. Documentation of specialist consult for the requested indication
References
1. Cosentyx (secukinumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals; June 2018

Review History
02/22/2016: Reviewed P&T Mtg
02/27/2017: Reviewed & Revised (added Step) P&T Mtg
03/01/2018: Reviewed & Revised (adopted MH RS) P&T Mtg
02/20/2019: Reviewed P&T Mtg
11/17/2021 – Reviewed and Updated for Nov P&T; matched MH UPPL; updated to reflect criteria changes based on literature; added appendix with diagnosis of hidradenitis suppurativa and higher dose/more frequent dosing guidelines.
11/17/2021 – Updated per MH UPPL: criteria for Taltz revised for psoriatic arthritis, ankylosing spondylitis and non-radiographic axial spondyloarthritis based on contract. Additionally, recertification criteria regarding Cosentyx requests approved for ankylosing spondylitis or non-radiographic axial spondyloarthritis prior to Taltz require was removed as this is no longer a requirement in the criteria.
Effective 01/01/2022

Disclaimer
AllWays Health Partners complies with applicable federal civil rights laws and does not discriminate or exclude people on the basis of race, color, national origin, age, disability, or sex.