FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Cosentyx® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Ankylosing spondylitis (for example: M45.0, M45.9)
❑ Plaque psoriasis (for example: psoriasis vulgaris, psoriasis; L40.0, L40.8, L40.9)
❑ Psoriatic arthritis (for example: arthropathic psoriasis; L40.5, L40.59)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of prior Cosentyx therapy? ❑ **Yes** ❑ **No**

Select if Cosentyx is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Rheumatologist

Will the patient be receiving Cosentyx in combination with a biologic disease-modifying antirheumatic drug DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

For ankylosing spondylitis, also answer the following:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to TWO non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following, or attestation demonstrating a trial may be inappropriate:
❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Simponi (golimumab)

For plaque psoriasis, also answer the following:

Does the patient have chronic moderate-to-severe disease? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
❑ Cimzia (certolizumab pegol) ❑ Humira (adalimumab) ❑ Skyrizi (risankizumab)
❑ Stelara (ustekinumab) ❑ Tremfya (guselkumab)

For psoriatic arthritis, also answer the following:

Does the patient have active disease? ❑ **Yes** ❑ **No**

Select if the patient has had a trial and failure, contraindication, or intolerance to the following:
❑ Cimzia (certolizumab) ❑ Humira (adalimumab) ❑ Simponi (golimumab) or Simponi Aria (golimumab IV) ❑ Stelara (ustekinumab)

Cosentyx® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

If this is a reauthorization request, please answer the following:

Is there documentation the patient has had a positive clinical response to Cosentyx therapy? ❑ **Yes** ❑ **No**

Is the patient receiving Cosentyx in combination with a biologic DMARD (e.g., Enbrel [etanercept], Humira [adalimumab], Cimzia [certolizumab], Simponi [golimumab])? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.