Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Cosentyx (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Louisiana at **1-844-699-2889**.
When conditions are met, we will authorize the coverage of Cosentyx (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Cosentyx (secukinumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ ICD Code: _____

Circle the appropriate answer for each question.

1. Is the requested drug prescribed for an approved diagnosis code? Y N

   Document diagnosis code: _____

   [If no, then no further questions.]

2. Is the requested drug prescribed according to U.S. Food and Drug Administration approved indications, dosing, safety and monitoring regulations? Y N

   [If no, then no further questions.]

3. Will the member be receiving the requested medication in combination with Y N

any other cytokine or CAM antagonist?

[If yes, then no further questions.]

4. Does the member have evidence of an active infection (including Hepatitis B virus and/or tuberculosis) within the last 180 days? Y N

   [If yes, then no further questions.]

5. Has the prescribing information for the requested medication been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements? Y N

   [If no, then no further questions.]

6. Have all laboratory testing and clinical monitoring recommended in the prescribing information been completed as of the date of the request and will be repeated as recommended? Y N

   [If no, then no further questions.]

7. Doe the member have any inappropriate concomitant drug therapies or disease states? Y N

   [If yes, then no further questions.]

8. Does the member have a diagnosis of ankylosing spondylitis? Y N

   [If no, skip to question 11.]

9. Is the requested medication prescribed by or in consultation with a rheumatologist? Y N

   [If no, then no further questions.]

10. Does the member have any of the following: A) a documented intolerable side effects or a documented failure with a non-steroidal anti-inflammatory agent (NSAID) during a single 3-month period, OR B) a contraindication to NSAIDs? Y N

    If yes, please list medication(s) tried, trial duration and outcome or contraindications:_____

    [If yes, skip to question 18.]

    [If no, then no further questions.]

11. Does the member have a diagnosis of psoriatic arthritis? Y N

[If no, skip to question 14.]

12. Is the requested medication prescribed by or in consultation with a dermatologist or rheumatologist? Y N

    [If no, then no further questions.]

13. Does the member have a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of at least one non-biologic disease modifying antirheumatic drug (DMARD) (such as methotrexate or leflunomide)? Y N

    If yes, please list medication(s) tried, trial duration and outcome or contraindications:_____

    [If yes, skip to question 18.]

    [If no, then no further questions.]

14. Does the member have a diagnosis of chronic moderate to severe plaque psoriasis? Y N

    [If no, then no further questions.]

15. Is the requested medication prescribed by or in consultation with a rheumatologist or dermatologist? Y N

    [If no, then no further questions.]

16. Does the member have any of the following: A) Body Surface Area (BSA) involvement of at least 3 percent or B) involvement of the palms, soles, head and neck or genitalia, causing disruption in normal activities and/or employment? Y N

    [If no, then no further questions.]

17. Does the member have a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of AT LEAST ONE of the following therapies: phototherapy, methotrexate, and/or cyclosporine? Y N

    If yes, please list therapies tried, trial duration and outcome or contraindications:_____

    [If no, then no further questions.]

18. Is the member 18 years of age or older? Y N

    [If no, then no further questions.]

19. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

    [If no, then no further questions.]

20. Is there evidence of a positive response to therapy as indicated by either maintenance of the current condition or improvement in signs and symptoms compared to baseline? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date