Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Cosentyx Intravenous
(secukinumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Cosentyx 125mg/5ml IV

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ new start of therapy ☐ continuation of therapy

If continuation of therapy:

(if continuation of therapy) Has the patient demonstrated a beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide support for continued use in your patient.

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Ankylosing spondylitis (AS, axial spondyloarthropathy)
☐ Crohn's disease (CD)
☐ Enthesitis-related arthritis
☐ Non-radiographic axial spondyloarthritis (nr-axSpA)
☐ Plaque psoriasis (psoriasis vulgaris, CPP, PsO)
☐ Psoriatic arthritis (PsA)
☐ Rheumatoid Arthritis (RA)
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Actemra, adalimumab (Humira and all biosimilars), Adbry, Bimzelx, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Ilumya, infliximab (Remicade and all biosimilars), Kevzara, Kineret, Litfulo, Olumiant, Omvoh, Orencia, Otezla, Rinvoq, rituximab (Rituxan and all biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Sotyktu, Stelara, Taltz, Tremfya, Tysabri, Velsipity, Xeljanz, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient will continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD
☐ Other

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient’s diagnosis.

Has your patient already tried a biologic or targeted synthetic DMARD (tsDMARD)? ☐ Yes ☐ No

If your patient has tried any of these, please provide the drug name and strength, date(s) taken and for how long, and what the documented results were of each, including any intolerances or adverse reactions your patient experienced.
If your patient has NOT tried any of these, please provide details why your patient can't try these alternatives.

Per the information given above, is there documentation that your patient has had failure or intolerance to any of the following? (check all that apply)

☐ Adalimumab Product (adalimumab-adaz/Hyrimoz [manufactured by Sandoz/Novartis], adalimumab – adbm/Cyltezo, or Humira)
☐ Other Adalimumab Product not listed above – please specify:
☐ Cimzia
☐ Cosentyx subcutaneous injection
☐ Enbrel
☐ Otezla
☐ Rinvoq
☐ Skyrizi SC
☐ Stelara SC
☐ Taltz
☐ Tremfya
☐ Xeljanz/XR
☐ Other:

Per the information given above, is there documentation that your patient has a contraindication to any of the following? Check all that apply. Any drug listed as failed or not tolerated in the previous question CANNOT be used for this question.

☐ Adalimumab Product (adalimumab-adaz/Hyrimoz [manufactured by Sandoz/Novartis], adalimumab – adbm/Cyltezo, or Humira)
☐ Other Adalimumab Product not listed above – please specify:
☐ Cimzia
☐ Cosentyx subcutaneous injection
☐ Enbrel
☐ Otezla
☐ Rinvoq
☐ Skyrizi SC
☐ Stelara SC
☐ Taltz
☐ Tremfya
☐ Xeljanz/XR
☐ Other:

(if PsA) Does your patient primarily have axial disease -OR- non-axial disease?
☐ Non-axial disease
☐ Axial disease

(if non-axial disease) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD).If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if non-axial disease) Per the information provided above, which of the following is true for your patient in regards to the covered alternative?

☐ The patient tried a DMARD, but it didn't work.
☐ The patient tried all DMARDs, but did not tolerate them.
☐ The patient cannot try any DMARDs because of a contraindication to each.
☐ Other

(if axial disease) The covered alternative is one disease-modifying anti-rheumatic drug (DMARD), or a nonsteroidal anti-inflammatory drug (NSAID). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

(if axial disease) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried a DMARD or NSAID, but it didn't work.
☐ The patient tried all DMARDs and NSAIDs, but did not tolerate them.
☐ The patient cannot try any DMARDs or NSAIDs because of a contraindication to each.
☐ Other

(if PsA) Is this medication being prescribed by, or in consultation with, a rheumatologist or dermatologist? ☐ Yes ☐ No

(if AS) The covered alternatives are nonsteroidal anti-inflammatory drugs (NSAIDs). If your patient has tried any NSAIDs, please provide the drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. If NSAIDs were NOT tried, please provide details why your patient can't try these drugs.

(if AS) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried an NSAID, but it didn't work well enough.
☐ The patient tried an NSAID, but they did not tolerate it.
☐ The patient cannot try an NSAID because of a contraindication to this drug.
☐ Other

(if AS, nr-axSpA) Is this drug being prescribed by, or in consultation with, a rheumatologist? ☐ Yes ☐ No

(if nr-axSpA) Does your patient have EITHER of the following objective signs of inflammation?

☐ C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory.
☐ Sacroiliitis reported on magnetic resonance imaging (MRI)
☐ None of the above or Unknown

Additional Information: *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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