# MEDICATION POLICY

**Generic Name:** Secukinumab

**Therapeutic Class or Brand Name:** Cosentyx®

**Applicable Drugs** (if Therapeutic Class)**:** N/A

**Date of Origin:** 8/25/16 **Date Last Reviewed/Revised:** 11/21/17

**GPI Code:** 9025057500

**Prior Authorization Criteria (may be considered medically necessary when criteria I through V are met):**

I. Documented diagnosis of one of the following conditions A through C AND must meet criteria listed under applicable diagnosis:
   A. Moderate to severe plaque psoriasis and criteria 1 through 3 are met:
      1. History of treatment failure, intolerance, or contraindication with phototherapy or photochemotherapy.
      2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.).
      3. Diagnosis must be established by a dermatologist or a rheumatologist.
   B. Active Psoriatic Arthritis and criterion 1 is met:
      1. Diagnosis must be established by a rheumatologist or dermatologist.
   C. Active Ankylosing Spondylitis and criterion 1 is met:
      1. Diagnosis must be established by a rheumatologist.

II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products).

III. Minimum age requirement: 18 years old.

IV. Absence of active serious infection or sepsis.

V. Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.

**Exclusion Criteria:**

- Coadministration of Cosentyx® with another biologic DMARD, Otezla® (apremilast), or Xeljanz®/ XR (tofacitinib). Examples of biologic DMARDs include the following:
  - Actemra® (tocilizumab)

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- Entyvio® (vedolizumab)
- Kevzara® (sarilumab)
- Kineret® (anakinra)
- Orencia® (abatacept)
- Rituxan® (rituximab)
- Siliq™ (brodalumab)
- Stelara® (ustekinumab)
- Taltz® (Ixekizumab)
- TNF inhibitors [Cimzia® (certolizumab pegol), Enbrel® (etanercept), Humira® (adalimumab), Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis™ (infliximab-abda), Simponi®/Simponi® Aria® (golimumab)]
- Tremfya™ (guselkumab)
- Tysabri® (natalizumab)

**Other Criteria:**

- N/A

**Quantity/Days Supply Restrictions:**

- Plaque Psoriasis:
  - Quantities of up to 10 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Psoriatic Arthritis:
  - Quantities of up to 5 syringes or pens for the first 28 days, then in quantities of up to 2 syringes or pens every 28 days thereafter.
- Ankylosing Spondylitis:
  - Quantities of up to 5 syringes or pens for the first 28 days, then 1 syringe or pen every 28 days thereafter.

**Approval Length:**

- **Authorization:** 1 year.

- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

**Appendix:**

N/A

**References:**

1. https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/cosentyx.pdf.
2. Medi-Span.

# MEDICATION POLICY

| *Historical Tracking Of Changes Made To Policy* | |
|---|---|
| *11/21/2017* | 1. **Added** "Kevzara® (sarilumab)"**,** "Siliq™ (brodalumab)"**, and** "Tremfya™ (guselkumab)" **to list under Exclusion Criteria**.<br>2. **Added** "Inflectra® (infliximab-dyyb)" **and** "Renflexis™ (infliximab-abda)" **following TNF Inhibitors to list under Exclusion Criteria**. |
| *12/2/2016* | 1. **Changed** "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one appropriate systemic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **to** "I. A. 2. History of treatment failure, intolerance, or contraindication with at least one systemic non-biologic agent (i.e. cyclosporine, methotrexate, acitretin, etc.)" **under Prior Authorization Criteria**.<br>2. **Changed** "II. Documented failure, intolerance, or contraindication to two preferred biologic products (refer to plan document for the list of preferred products)" **to** "II. Documented failure, intolerance, or contraindication to at least one preferred tumor necrosis factor (TNF) inhibitor (refer to plan document for the list of preferred products)" **under Prior Authorization Criteria**. |