US Family Health Plan
Prior Authorization Request Form for
Secukinumab (Cosentyx)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior Authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete clinical assessment:**

1. Humira is the Department of Defense's preferred targeted biologic agent. Has the patient tried Humira?	☐ Yes Proceed to question **2**	☐ No Proceed to question **4**
2. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **3**
3. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 18 years of age or older?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**

6. What is the indication or diagnosis for this adult patient?	☐ Active psoriatic arthritis (PsA) – Proceed to question **13** ☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **13** ☐ Active ankylosing spondylitis (AS) – Proceed to question **14** ☐ Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation – Proceed to question **14** ☐ Moderate to severe hidradenitis suppurativa (HS) – Proceed to question **13** ☐ Generalized pustular psoriasis (GPP) – Proceed to question **12** ☐ Other indication or diagnosis – **STOP: coverage not approved**

7. What is the indication or diagnosis for this pediatric patient?	☐ Moderate to severe plaque psoriasis in a patient who is a candidate for systemic therapy or phototherapy – Proceed to question **8** ☐ Active enthesitis-related arthritis (ERA) – Proceed to question **9** ☐ Active psoriatic arthritis (PsA) – Proceed to question **10** ☐ Generalized pustular psoriasis (GPP) – Proceed to question **11** ☐ Other indication or diagnosis – **STOP: coverage not approved**	
8. How old is the patient?	☐ Greater than or equal to 6 years of age and Less than or equal to 17 years of age – Proceed to question **13** ☐ Other – **STOP Coverage not approved**	
9. How old is the patient?	☐ Greater than or equal to 4 years of age and Less than or equal to 17 years of age – Proceed to question **15** ☐ Other – **STOP Coverage not approved**	
10. How old is the patient?	☐ Greater than or equal to 2 years of age and Less than or equal to 17 years of age – Proceed to question **13** ☐ Other – **STOP Coverage not approved**	
11. How old is the patient?	☐ Greater than or equal to 12 years of age and Less than or equal to 17 years of age – Proceed to question **12** ☐ Other – **STOP Coverage not approved**	
12. Does the patient have a history of at least two generalized pustular psoriasis flares of moderate-to-severe intensity in the past?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient had an inadequate response to non-biologic systemic therapy? For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], antibiotics, anti-androgens, etc.	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
14. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Will the patient be receiving other targeted immunomodulatory biologics with Cosentyx, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____