Secukinumab (Cosentyx®)	Place of Service Office Administration Home Health Administration Outpatient Facility Infusion Administration Infusion Center Administration Self-Administration – *May be covered under the pharmacy benefit* HCPCS: J3590 NDC 0078-0639-41: Carton of two 150 mg/mL (300mg dose) Sensoready pens NDC 0078-0639-68: Carton of one 150 mg/mL single-use Sensoready pen NDC 0078-0639-97: Carton of one 150 mg/mL single-use prefilled syringe NDC 0078-0639-98: Carton of two 150 mg/mL (300 mg dose) single-use prefilled syringes

Conditions listed in policy (*see criteria for details*)

- Enthesitis-related arthritis (ERA)
- Plaque psoriasis
- Psoriatic arthritis
- Spondyloarthritis

AHFS therapeutic class: Antipsoriatic agent, systemic

Mechanism of action: Interleukin-17 antagonist monoclonal antibody

(1) Special Instructions and pertinent Information

This drug is managed under the outpatient Pharmacy Benefit for self-administration. Please contact the member's Pharmacy Benefit for information on how to obtain this drug.

To submit a request to the Medical Benefit, please submit clinical information for prior authorization review and include medical rationale why the patient cannot self-administer this drug in the home.

For plans with self-injectables under the Medical Benefit, please submit clinical information for prior authorization review via fax.

(2) Prior Authorization/Medical Review is required for the following condition(s)

All requests for Cosentyx® (secukinumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

Enthesitis-related arthritis (ERA)

1. Age ≥ 4 years of age, **AND**
2. Prescribed by or in consultation with a rheumatologist, **AND**
3. Inadequate response or intolerable side effect with one NSAID, or contraindication to all NSAIDs, **AND**

4. Not being used in combination with other targeted immunomodulators (i.e., anti-TNFs, interleukin inhibitors)

Covered Doses
Up to 150 mg SC at Weeks 0, 1, 2, 3, and 4, followed by up to 150 mg every 4 weeks

Coverage Period
Cover yearly, based upon continued response.

ICD-10:
M08.8

Plaque Psoriasis

1. Disease is moderate to severe, **AND**
2. Age ≥ 6 years of age, **AND**
3. Prescribed by or in consultation with a dermatologist or rheumatologist, **AND**
4. Documentation of one of the following:
    a. Baseline PASI score is 10 or more prior to starting biological therapy, or
    b. Baseline BSA (body surface area) affected is 3% or more prior to starting biological therapy, or
    c. Sensitive area is involved (i.e. groin, face, etc.), or
    d. Disease is otherwise debilitating

    AND
5. Inadequate response, intolerable side effect, or contraindication to one of the following:
    a. Methotrexate, cyclosporine (Neoral®), acitretin (Soriatane®), or
    b. PUVA or UVB treatment

    AND
6. Not used with Otezla or another targeted biologic, **AND**
7. Inadequate response or intolerable side effect with two BSC-preferred agents, Enbrel, Humira, infliximab (Inflectra or Avsola), Otezla, Skyrizi, Stelara, Taltz, Tremfya, or contraindication to all preferred agents

Covered Doses
Up to 300 mg SC at Weeks 0, 1, 2, 3, and 4 followed by 300 mg every 4 weeks.

Coverage Period
Initial: 24 weeks
Reauthorization: Yearly if meets the following:

1. Not being used in combination with other targeted biologics, AND
2. One of the following:
    a. Improvement in PASI score from baseline, OR
    b. Improvement in BSA from baseline, OR
    c. Decrease in sensitive area disease severity, OR
    d. Decrease in debilitating disease severity

ICD-10:
L40.0-L40.4

Psoriatic arthritis

1. Prescribed by or in consultation with a rheumatologist, **AND**
2. Age ≥ 2 years, **AND**
3. Inadequate response, or intolerable side effect with one DMARD agent or patient has a medical reason why methotrexate, leflunomide and sulfasalazine cannot be used, **AND**
4. Not being used in combination with other targeted immunomodulators (i.e., anti-TNFs, interleukin inhibitors, Otezla), **AND**
5. Inadequate response or intolerable side effect with two BSC-preferred agents, Enbrel, Humira, infliximab (Inflectra or Avsola), Otezla, Rinvoq, Skyrizi, Stelara, Taltz, Tremfya, and Xeljanz/Xeljanz XR, or contraindication to all preferred agents

Covered Doses*
With loading dose: Up to 150 mg SC at Weeks 0, 1, 2, 3, and 4, followed by up to 300 mg every 4 weeks
Without loading dose: Up to 150 mg SC every 4 weeks
**For concomitant plaque psoriasis and PsA, cover dosing for plaque psoriasis*

Coverage Period
Cover yearly, based upon continued response.

ICD-10:
L40.50-L40.59

Spondyloarthritis

1. Prescribed by or in consultation with a rheumatologist, **AND**
2. Not used in combination with other targeted immunomodulators (i.e., anti-TNFs, interleukin inhibitors), **AND**
3. One of the following:
    a. Patient unable to use NSAIDs due to history of GI bleed or ulcer, or
    b. For patient with high-risk potential for development of GI bleed or ulcer: Inadequate response or intolerable side effect to ONE prescription-strength oral NSAID in combination with a proton pump inhibitor (PPI), or
    c. For patient with no bleeding or ulcer risk factors: Either inadequate response or nonGI related intolerable side effect with two prescription-strength oral NSAIDs, or intolerable GI side effect with ONE prescription-strength oral NSAID monotherapy not relieved with addition of concomitant proton pump inhibitor (PPI) therapy.

AND

4. Inadequate response or intolerable side effect with two preferred agents Enbrel, Humira, infliximab (Inflectra or Avsola), Taltz, Rinvoq, and Xeljanz/Xeljanz XR, or contraindication to ALL preferred agents

Covered Doses*
With loading dose: Up to 150 mg SC at Weeks 0, 1, 2, 3, and 4, followed by up to 300 mg every 4 weeks

Without loading dose: Up to 150 mg SC every 4 weeks

**For concomitant plaque psoriasis and PsA, cover dosing for plaque psoriasis*

Coverage Period
Cover yearly, based upon continued response

ICD-10:
M45.0-M45.9, M48.8X1-M48.8X9

(3) The following condition(s) DO NOT require Prior Authorization/Preservice

All requests for Cosentyx® (secukinumab) must be sent for clinical review and receive authorization prior to drug administration or claim payment.

(4) This Medication is NOT medically necessary for the following condition(s)

Coverage for a Non-FDA approved indication, requires that criteria outlined in Health and Safety Code § 1367.21, including objective evidence of efficacy and safety are met for the proposed indication.

Please refer to the Provider Manual and User Guide for more information.

(5) Additional Information

How supplied:
Injection: 150 mg (single-use Sensoready® pen)
Injection: 150 mg (single-use prefilled syringe)

For Injection: 150 mg, lyophilized powder in a single-use vial for reconstitution for healthcare professional use only

(6) References

- AHFS®. Available by subscription at http://www.lexi.com
- Cosentyx (secukinumab) [Prescribing Information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation. 12/ 2021.
- DrugDex®. Available by subscription at http://www.micromedexsolutions.com/home/dispatch
- Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol 2019; 80: 1029-72.
- Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. Journal of Psoriasis and Psoriatic Arthritis. 2019; 4(1): 31-58.
- Ward MM, Deodhar A, Gensler LS, Dubreuil M. et al. Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. Arthritis Rheumatol. 2019;71:1599–613
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(7) Policy Update

Date of last revision: 4Q2022
Date of next review: 4Q2023
Changes from previous policy version:

- No clinical change to policy following routine annual review.

BSC Drug Coverage Criteria to Determine Medical Necessity
Reviewed by P&T Committee