Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Cosentyx® (secukinumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Cosentyx 150 mg Pen ☐ Cosentyx 150 mg Syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosage & dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be used for a medically-accepted indication*
    a. For ankylosing spondylitis:
        i. Must have presence of disease for 4 weeks or longer
        ii. Must first try a therapeutic dose of one NSAID during a single 3-month period
        iii. Must first try Enbrel or Humira
    b. Plaque psoriasis
        i. Must affect 5% or more of patient's body surface area (unless hands, feet, neck, or genitalia affected)
        ii. Must first try one non-biologic disease modifying antirheumatic drug (DMARD)
        iii. Must first try Enbrel or Humira
    c. Psoriatic arthritis
        i. Must first try one non-biologic disease modifying antirheumatic drug (DMARD)
        ii. Must first try Enbrel or Humira
2. Must be age 18 or older
3. Must have a negative TB test in the last 12 months

Additional information

Note: When criteria are met, duration of approval is 1 year

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 01/2019
Last reviewed 01/2019

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the date and result of the patient's last TB test?

☐ Negative **Date:** _____
☐ Positive
☐ Not completed. **Are you requesting an exception to the criteria?**
☐ Yes. ***Rationale for exception***: _____
☐ No

Covered condition **(Place an "X" in the box for the condition this drug is being requested for.)**	**Requirements that must be met before the drug is covered** **(Place an "X" in the appropriate box to indicate the patient has met the required criteria.)**
☐ Ankylosing spondylitis	**1. Has the patient had presence of disease for 4 weeks or longer?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No **2. Has the patient tried a therapeutic dose of one NSAID during a single 3-month period?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No **3. Has the patient tried Enbrel or Humira?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No
☐ Plaque psoriasis	**1. Does the patient have any the following?** ☐ more than 5% body surface area ☐ neck ☐ hands ☐ genitalia ☐ feet ☐ head ☐ None. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No **2. Has the patient tried one non-biologic DMARD?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No **3. Has the patient tried Enbrel or Humira?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 01/2019

☐ Psoriatic arthritis	**1. Has the patient tried one non-biologic DMARD?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No **2. Has the patient ried Enbrel or Humira?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. *Rationale for exception*: _____ ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Cosentyx likely be the most effective option for this patient?
☐ No
☐ Yes, because:_____

_____

_____

If the patient is currently using Cosentyx, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ No
☐ Yes, because:_____

_____

_____

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 01/2019