Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ Frequency: _____ Strength: _____
Route of Administration: _____ Expected Length of Therapy: _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What is the prescribed quantity and frequency?
   a) **Loading dose:**
   ❑ Cosentyx 75 mg Quantity and Frequency: _____
   ❑ Cosentyx 150 mg Quantity and Frequency: _____
   ❑ Cosentyx 300 mg Quantity and Frequency: _____
   ❑ Other _____
   b) **Maintenance dose:**
   ❑ Cosentyx 75 mg Quantity and Frequency: _____
   ❑ Cosentyx 150 mg Quantity and Frequency: _____
   ❑ Cosentyx 300 mg Quantity and Frequency: _____
   ❑ Other _____
2. What is the diagnosis?
   ❑ Moderate to severe plaque psoriasis
   ❑ Active ankylosing spondylitis
   ❑ Active Non-radiographic axial spondyloarthritis
   ❑ Active psoriatic arthritis **WITHOUT** co-existent plaque psoriasis
   ❑ Active psoriatic arthritis
   Please indicate primary diagnosis being treated:
   ❑ Active psoriatic arthritis ❑ Moderate to severe plaque psoriasis
   ❑ Enthesitis related arthritis
   ❑ Hidradenitis suppurativa
   ❑ Other, please specify. _____
3. What is the ICD-10 code? _____
4. What is the patient's weight? _____ kg
5. Is the requested drug being prescribed by or in consultation with a dermatologist or rheumatologist?
   ❑ Dermatologist ❑ Rheumatologist ❑ None of the above
6. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication? ❑ Yes ❑ No
7. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
   If Yes, skip to #11 ❑ Yes ❑ No

8. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 6 months of initiating therapy? ❑ Yes ❑ No

9. What were the results of the tuberculosis (TB) test?
❑ Positive for TB ❑ Negative for TB, *skip to #11* ❑ Unknown

10. Which of the following applies to the patient?
❑ Patient has latent TB and treatment for latent TB has been initiated
❑ Patient has latent TB and treatment for latent TB has been completed
❑ Patient has latent TB and treatment for latent TB has not been initiated
❑ Patient has active TB

11. Is this request for continuation of therapy with the requested drug?
❑ Yes ❑ No *If No, skip to diagnosis section.*

12. Is the patient currently receiving the requested drug through samples or a manufacturers patient assistance program? ❑ Yes ❑ No ❑ Unknown

13. Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❑ Yes ❑ No

Complete the following section based on the patient's <u>primary</u> diagnosis, if applicable.

<u>Section A: Plaque Psoriasis</u>

Continuation

1. Has the patient experienced a reduction in body surface area (BSA) affected from baseline?
ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected and no further questions. ❑ Yes ❑ No

2. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.*** ❑ Yes ❑ No

Initiation

3. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

4. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?
ACTION REQUIRED: If Yes, please attach chart notes or medical record documentation of affected areas and no further questions. ❑ Yes ❑ No

5. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%? ❑ Yes ❑ No

6 What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)?
ACTION REQUIRED: Please attach chart notes or medical record documentation of body surface area affected. _____ ***%*** *If greater than or equal to 10%, no further questions.*

7. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

8. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

9. Please indicate the clinical reason to avoid pharmacologic treatment. with methotrexate, cyclosporine, and acitretin.
   - ❑ Drug interaction
   - ❑ Breastfeeding
   - ❑ Hypersensitivity
   - ❑ Risk of treatment-related toxicity
   - ❑ Pregnancy or currently planning pregnancy
   - ❑ History of intolerance or adverse event
   - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
   - ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
   - ❑ Other, please specify. _____

Section B: Ankylosing Spondylitis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)

Continuation

1. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: Please attach chart notes or medical record documentation of positive clinical response.***
   - ❑ Functional status
   - ❑ C-reactive protein (CRP)
   - ❑ Tender joints
   - ❑ Total spinal pain
   - ❑ Inflammation (e.g., morning stiffness)
   - ❑ None of the above
   - ❑ Swollen joints

2. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose? ❑ Yes ❑ No

3. *If the prescribed dose exceeds 150 mg AND diagnosis is for Ankylosing Spondylitis,* did the patient continue to have active ankylosing spondylitis at the 150 mg dose? ❑ Yes ❑ No ❑ N/A, prescribed dose does not exceed 150mg and/or diagnosis is NOT for Ankylosing Spondylitis

Initiation

4. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

5. Has the patient had an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least TWO NSAIDs? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

Section C: Psoriatic Arthritis

Continuation

1. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED: If Yes, Please attach chart notes or medical record documentation of improvement in signs and symptoms.***
   - ❑ Number of swollen joints
   - ❑ Enthesitis
   - ❑ Functional status
   - ❑ Number of tender joints
   - ❑ Axial disease
   - ❑ C-reactive protein (CRP)
   - ❑ Dactylitis
   - ❑ Skin and/or nail involvement
   - ❑ None of the above

2. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose? ❑ Yes ❑ No

3. *If the prescribed dose exceeds 150 mg,* did the patient continue to have active psoriatic arthritis at the 150 mg dose? ❑ Yes ❑ No ❑ N/A, prescribed dose does not exceed 150mg

Initiation

4. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried and no further questions.*** ❑ Yes ❑ No

5. What is the patient's disease severity?
   ❑ Mild to moderate disease ❑ Severe disease *If No, no further questions.*

6. Does the patient have enthesitis or predominantly axial disease? *If Yes, no further questions.* ❑ Yes ❑ No

7. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

8. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

9. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy and skip to #37.*** ❑ Yes ❑ No

10. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.***
    ❑ Yes ❑ No *No further questions*.

11. Please indicate the contraindication to methotrexate or leflunomide.
    ❑ Drug interaction
    ❑ Breastfeeding
    ❑ Hypersensitivity
    ❑ Risk of treatment-related toxicity
    ❑ Pregnancy or currently planning pregnancy
    ❑ History of intolerance or adverse event
    ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
    ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
    ❑ Other, please specify. _____

Section D: Enthesitis Related Arthritis (ERA)

Continuation

1. Which of the following has the patient experienced an improvement in from baseline?
   ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.
   ❑ Number of joints with active arthritis (e.g., swelling, pain)
   ❑ Number of joints with limited movement
   ❑ Dactylitis
   ❑ None of the above
   ❑ Enthesitis
   ❑ Number of flares
   ❑ Axial disease

Initiation

2. Has the patient ever received or is currently receiving a biologic indicated for the treatment of active enthesitis-related arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.*** ❑ Yes ❑ No

3. Does the patient's disease demonstrate at least three active joints involved and at least one site of active enthesitis at baseline or documented by history? ❑ Yes ❑ No

4. Has the patient experienced an inadequate response to nonsteroidal anti-inflammatory drugs (NSAIDs), sulfasalazine, or methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

5. Has the patient experienced an intolerance or contraindication to nonsteroidal anti-inflammatory drugs (NSAIDs) AND sulfasalazine (e.g., porphyria, intestinal or urinary obstruction)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

6. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

7. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

8. Please indicate the contraindication to methotrexate.
   - ❑ Drug interaction
   - ❑ Breastfeeding
   - ❑ Hypersensitivity
   - ❑ Risk of treatment-related toxicity
   - ❑ Pregnancy or currently planning pregnancy
   - ❑ History of intolerance or adverse event
   - ❑ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
   - ❑ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
   - ❑ Other, please specify _____

Section E: Hidradenitis Suppurativa

Continuation

1. Which of the following has the patient experienced an improvement in since starting treatment with the requested drug? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.***
   - ❑ Reduction in abscess and inflammatory nodule count from baseline
   - ❑ Reduced formation of new sinus tracts and scarring from baseline
   - ❑ Improvement on a disease severity assessment tool from baseline
   - ❑ Improvement in frequency of relapses from baseline
   - ❑ Reduction in suppuration from baseline
   - ❑ Decrease in frequency of inflammatory lesions from baseline
   - ❑ Reduction in pain from baseline
   - ❑ Improvement in quality of life
   - ❑ None of the above

Initiation

2. Has the patient ever received or is currently receiving a biologic indicated for the treatment of moderate to severe hidradenitis suppurativa (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medication tried and no further questions.*** ❑ Yes ❑ No

3. Has the patient experienced an inadequate response after at least 90 days of treatment with an oral antibiotic used for the treatment of hidradenitis suppurativa (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines)? ***ACTION REQUIRED: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy and no further questions.*** ❑ Yes ❑ No

4. Does the patient have a contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa? ***ACTION REQUIRED: If Yes, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date