Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Cosentyx® (secukinumab)**

Effective: January 1, 2024

Guideline Type	☒ Prior Authorization ☐ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Cosentyx (secukinumab) is an interleukin-17A antagonist indicated for:

Disease State	
Ankylosing Spondylitis	X
Hidradenitis Suppurativa	X
Enthesitis-related Arthritis	X
Non-radiographic Axial Spondyloarthritis	X
Plaque Psoriasis	X
Psoriatic Arthritis	X

Clinical Guideline Coverage Criteria

The plan may authorization coverage of Cosentyx for Members when all of the following criteria are met:

Ankylosing Spondylitis

1. Documented diagnosis of ankylosing spondylitis

AND

2. Patient is at least 18 years of age

AND

3. Prescribed by or in consultation with a rheumatologist

AND

4. Documentation of **one (1)** of the following:
    a. All of the following:
        i. One (1) of the following:
            1. Inadequate response or adverse reaction to one (1), or contraindication to all prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam)
            2. Previous treatment with a biologic agent indicated for the requested use
        ii. Trial and failure with two (2), or contraindication to all of the following: Cimzia, Enbrel, Humira, Rinvoq,

Simponi, Xeljanz

iii. Trial and failure with or contraindication to Taltz

b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Enthesitis-related Arthritis

1. Documented diagnosis of enthesitis-related arthritis

AND

2. Patient is at least 4 years of age

AND

3. Prescribed by or in consultation with a rheumatologist

Hidradenitis Suppurativa

1. Documented diagnosis of hidradenitis suppurativa

AND

2. Patient is at least 18 years of age

AND

3. Prescribed by or in consultation with a dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. Both of the following:
        i. Inadequate response to at least three (3) of the following conventional treatments
            1. Local hygiene and ordinary hygiene
            2. Weight reduction in patients who are obese
            3. Use of ordinary soaps and antiseptic and antiperspirant agents (e.g., aluminum chloride hexahydrate iv).
            4. Application of warm compresses with sodium chloride solution or Burow's solution
            5. Laser hair removal
            6. Cessation of cigarette smoking
            7. Medical anti-inflammatory or antiandrogen therapy such as oral or topical antibiotics, intralesional triamcinolone, spironolactone, or finasteride
        ii. Trial and failure with or contraindication to Humira
    b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes.

Non-radiographical Axial Spondyloarthritis

1. Documented diagnosis of non-radiographic axial spondyloarthritis

AND

2. Patient is at least 18 years of age

AND

3. Prescribed by or in consultation with a rheumatologist

AND

4. Documentation of objective signs of inflammation

AND

5. Documentation of **one (1)** of the following:
    a. Both of the following:
        i. One (1) of the following:
            1. Inadequate response or adverse reaction to one (1), or contraindication to all prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam)
            2. Previous treatment with a biologic agent indicated for the requested use
        ii. Trial and failure with or contraindication to all of the following: Cimzia, Rinvoq, Taltz

b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Plaque Psoriasis

1. Documented diagnosis of plaque psoriasis

AND

2. Patient is at least 6 years of age

AND

3. Prescribed by or in consultation with a dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. All of the following:
        i. One (1) of the following:
            1. Inadequate response to one (1), or contraindication to all of the following topical therapies: corticosteroids, vitamin D analogs, tazarotene, calcineurin inhibitors, anthralin, coal tar
            2. Previous treatment with a biologic agent indicated for the requested use
        ii. Trial and failure with three (3), or contraindication to all of the following: Cimzia, Enbrel, Humira, Skyrizi, Stelara, Tremfya
        iii. Trial and failure with or contraindication to Taltz
    b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Psoriatic Arthritis

1. Documented diagnosis of psoriatic arthritis

AND

2. Patient is at least 2 years of age

AND

3. Prescribed by or consultation with a rheumatologist or dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. Both of the following:
        i. Trial and failure with two (2), or contraindication to all of the following: Cimzia, Enbrel, Humira, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya, Xeljanz
        ii. Trial and failure with both, or contraindication to Orencia and Taltz
    b. The patient is new to the plan and stable on Cosentyx and the prescribing physician has documented that changing to a preferred product would result in adverse clinical outcomes

Limitations

1. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response and will not be considered for prior authorization.
2. Documentation of a Member being a social drinker does not qualify as a medically acceptable contraindication or clinical inappropriateness to methotrexate therapy.

Codes

None

References

1. Cosentyx (secukinumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2023.
2. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. Arthritis Rheumatol. 2019;71(1):5-32.
3. 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.

4. Ward MM, Deodhar A, Gensler LS, et al. 2019 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(10):1599-1613.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- September 2022 e-vote: Effective January 1, 2023, Enbrel added as a preferred agent.
- February 14, 2023: Included Rinvoq as a prerequisite option for non-radiographic axial spondyloarthritis (eff 2/17/23).
- December 12, 2023: Added coverage criteria for supplemental indication for hidradenitis suppurativa (eff 1/1/2024).

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.