Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Cosentyx (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Cosentyx (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(please circle)***

Cosentyx

Other, please specify____

Quantity ___________ Frequency ________________ Strength ____________

Route of Administration ___________ Expected Length of therapy _______________

Patient Information

Patient Name: ___________________________________

Patient ID: ___________________________________

Patient Group No.: ___________________________________

Patient DOB: ___________________________________

Patient Phone: ___________________________________

Prescribing Physician

Physician Name: ____

Specialty: ____________________________ NPI Number: __________________________

Physician Fax: ____________________________ Physician Phone: __________________________

Physician Address: ____________________________ City, State, Zip: __________________________

Diagnosis:______________________________ ICD Code:______________________________

Please circle the appropriate answer for each question.

1. Has this plan authorized Cosentyx in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Has the patient had at least a 20% improvement in symptoms? Y N

   [No further questions.]

3. Does the patient have a diagnosis of plaque psoriasis? Y N

   [If no, then skip to question10.]

4. Does the patient have more than 10% of body surface area involvement with plaque psoriasis or has a PASI score of more than 10? Y N

   [If no, then no further question.]

5. Has the patient failed standard topical therapies? Y N

   List topical therapies tried:
   ____

   [If no, then no further questions.]

6. Has the patient tried and had an insufficient response to phototherapy (UVB or PUVA) or is unable to receive phototherapy? Y N

   If yes, please provide rationale:__________________________

   [If no, then no further questions.]

7. Has the patient had failure to an adequate trial (3 months) of methotrexate or cyclosporine? Y N

   [If yes, then skip to question 9.]

8. Does the patient have a contraindication to both methotrexate and cyclosporine? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindications: _________________

   [If no, then no further questions.]

9. Does the plaque psoriasis have a significant impact on physical, psychological, or social wellbeing? Y N

   [If yes, then skip to question 23.]

   [If no, then no further questions.]

10. Does the patient have a diagnosis of psoriatic arthritis (PsA)? Y N

    [If no, skip to question 19.]

11. Does the patient have primarily axial disease (involving the spine) or active enthesitis/dactylitis? Y N

[If no, skip to question 13.]

12. Has the patient tried an adequate trial (3 months) with at least 2 different NSAIDs and had inadequate response? Y N

    If yes, please list medications tried:______________________

    [If yes, skip to question 17.]

    [If no, skip to question 18.]

13. Does the patient have active psoriatic arthritis? Y N

    [If no, then no further questions.]

14. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

    [If yes, skip to question 17.]

15. Does the patient have a contraindication to methotrexate? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:__________________

    [If no, then no further questions.]

16. Has the patient had failure to an adequate trial (3 months) of sulfasalazine or leflunomide? Y N

    [If no, then no further questions.]

17. Is the patient currently on or will continue taking an NSAID with requested medication? Y N

    [If yes, then skip to question 23.]

18. Does the patient have contraindications to NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication:__________________

    [If yes, then skip to question 23.]

    [If no, then no further questions.]

19. Does the patient have a diagnosis of ankylosing spondylitis (AS)? Y N

    [If no, then no further question.]

20. Does the patient have unacceptable disease activity despite an adequate trial (3 months) with at least 2 different NSAIDs? Y N

    If yes, please list medications tried:______________________

    [If no, skip to question 22.]

21. Is the patient currently on or will continue taking an NSAID with the requested medication? Y N

    [If yes, skip to question 23.]

22. Does the patient have contraindications to NSAIDs? Y N

    Note: Contraindications such as true allergic reaction to NSAIDs, history of worsening asthma symptoms after taking aspirin or NSAIDs, current GI bleed, severe renal dysfunction.

    If yes, please document contraindication:__________________

    [If no, then no further questions.]

23. Has the patient had a trial and failure of at least one formulary anti-TNF (tumor necrosis factor inhibitor)? Y N

    [If no, then no further questions.]

24. Is the patient at least 18 years of age? Y N

    [If no, then no further questions.]

25. Is Cosentyx being prescribed by, or in consultation with a specialist, based on indication (rheumatologist, dermatologist)? Y N

    [If no, then no further questions.]

26. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

27. Does the patient have an active infection (including Hepatitis B and/or tuberculosis (TB)? Y N

[If no, then no further questions.]

28. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature **Date**