I. Medication Description

Cosentyx® (secukinumab) is a human IgG1 monoclonal antibody that selectively binds to the interleukin-17A (IL-17A) cytokine, which inhibits its interaction with the IL-17A receptor. IL-17A is involved in normal inflammatory and immune responses. Elevated concentrations of IL-17A are found in psoriatic plaques.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

III. Policy

Coverage for Cosentyx is provided for adult members for the following conditions when the listed criteria are met:

- Ankylosing spondylitis (active disease):
  - Prescribed by a rheumatologist AND
  - The member has had inadequate results with at least two NSAIDs (unless NSAIDs are contraindicated)

- Plaque psoriasis (moderate to severe disease):
  - Prescribed by a rheumatologist or dermatologist AND
  - At least 10% of BSA affected or less than 10% BSA affected but with palmar, plantar, head/neck, or genitalia involvement AND
  - Member has had an inadequate response to PUVA or UVB therapy unless contraindicated AND
  - Member has had an inadequate response to non-biologic systemic therapy (i.e. methotrexate, cyclosporine, acitretin) unless contraindicated

- Psoriatic arthritis (active disease):
  - Prescribed by a rheumatologist or dermatologist AND
  - One of the following:
    - Member has tried therapy with at least one non-biologic DMARD with either treatment failure after 12 weeks or intolerable side effects (unless DMARDs are contraindicated) OR
    - If predominantly axial disease is documented, the member has experienced treatment failure with at least two oral NSAIDs (unless NSAIDs are contraindicated)
IV. **Quantity Limitations**

- Quantity will be limited to 2 pens/syringes (300 mg) every month, with exceptions as outlined below:
  - Initial 30 days- 10 pens/syringes (1,200 mg)

V. **Coverage Duration**

Coverage will be authorized for 12 months and may be renewed.

VI. **Coverage Renewal Criteria**

Coverage can be renewed based upon the following criteria:

- Clinical response or remission of disease is maintained with continued use **AND**
- Absence of unacceptable toxicity from the drug

VII. **Billing/Coding Information**

Available as a carton of one or two 150 mg/mL Sensoready pens or prefilled syringes

VIII. **Summary of Policy Changes**

- 6/15/15: new policy
- 7/1/15: formulary distinctions made
- 12/15/15: no policy changes
- 1/19/16: criteria for coverage of the treatment of ankylosing spondylitis and psoriatic arthritis added in response to new FDA-approved indications
- 9/15/16: no policy changes
- 1/1/17: step therapy rules updated; trials with Enbrel and Humira no longer required
- 9/8/17: obsolete lyophilized powder vial removed from policy
- 10/11/17: no policy changes

IX. **References**


The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary medication will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.