Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Cosentyx® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Psoriatic arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if Cosentyx is prescribed by one of the following specialists:

- ❑ Dermatologist
- ❑ Rheumatologist

Has the patient tried and failed both Enbrel AND Humira? ❑ **Yes** ❑ **No**

For ankylosing spondylitis or psoriatic arthritis, also answer the following:

Select if the patient has tried and failed the following disease-modifying antirheumatic drugs (DMARDs) for at least three (3) months:

- ❑ Auranofin ❑ Hydroxychloroquine ❑ Methotrexate
- ❑ Azathioprine ❑ Leflunomide ❑ Sulfasalazine

For moderate to severe chronic plaque psoriasis, also answer the following:

Select if the patient has tried and failed the following DMARDs:

- ❑ Auranofin ❑ Hydroxychloroquine ❑ Methotrexate
- ❑ Azathioprine ❑ Leflunomide ❑ Sulfasalazine

Select if the patient has tried and failed of the following UV light therapies:

- ❑ NB UV-B
- ❑ PUVA

Select if the patient has tried and failed the following oral alternative systemic therapies:

- ❑ Acitretin
- ❑ Methotrexate
- ❑ Cyclosporine

Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Cosentyx® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.