Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Cosentyx Intravenous
(secukinumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Cosentyx 125mg/5ml IV

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:

What is your patient's current weight?

Is this a new start or continuation of therapy with the requested medication?
☐ new start of therapy ☐ continuation of therapy

(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

What is the indication or diagnosis?

☐ Ankylosing spondylitis (AS)
☐ Crohn's disease (CD)
☐ Enthesitis-related arthritis
☐ Hidradenitis Suppurativa
☐ Non-radiographic axial spondyloarthritis (nr-axSpA)
☐ Plaque psoriasis (PsO)
☐ Psoriatic arthritis (PsA)
☐ Rheumatoid Arthritis (RA)
☐ other (please specify):

Clinical Information:

Will the requested medication be used in combination with a BIOLOGIC or with a targeted synthetic oral small molecule?
☐ Biologic (an adalimumab product [Humira, biosimilar], Bimzelx, Cimzia, Cosentyx SC, etanercept SC product [Enbrel, biosimilar], Entyvio (IV or SC), Ilumya, infliximab IV products [Remicade, biosimilar], Kevzara, Kineret, Omvoh (IV or SC), Orencia [IV or SC], a rituximab IV product [Rituxan, biosimilar], Skyrizi (IV or SC), Siliq, Simponi [Aria or SC]), an ustekinumab product (Stelara [IV or SC], biosimilar), Taltz, a tocilizumab product [Actemra (IV or SC), biosimilar], Tremfya (IV or SC), or Zymfentra.
☐ Targeted synthetic oral small molecule drug (such as Cibinqo, Leqselvi, Litfulo, Sotyktu, Olumiant, Otezla, Otezla XR, Rinvoq, Rinvoq LQ, Xeljanz, Xeljanz XR, Velsipity, or Zeposia)
☐ Conventional synthetic DMARD (such as methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)
☐ No, Cosentyx will NOT be used in combination with another BIOLOGIC or targeted synthetic oral small molecule drug.

If Ankylosing spondylitis:

Is the patient currently receiving Cosentyx intravenous or subcutaneous? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Cosentyx intravenous or subcutaneous? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Cosentyx intravenous or subcutaneous. ☐ Yes ☐ No

Is Cosentyx being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating Cosentyx intravenous or subcutaneous)? Please Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondyloarthropathies (HAQ-S), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate). ☐ Yes ☐ No

Compared with baseline (prior to receiving Cosentyx intravenous or subcutaneous), has the patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living? ☐ Yes ☐ No

If Non-radiographic axial spondyloarthritis:

Is the patient currently receiving Cosentyx intravenous or subcutaneous? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Cosentyx intravenous or subcutaneous? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Cosentyx intravenous or subcutaneous. ☐ Yes ☐ No

Does the patient have objective signs of inflammation, defined as C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory? ☐ Yes ☐ No

Does the patient have objective signs of inflammation, defined as sacroiliitis reported on magnetic resonance imaging? ☐ Yes ☐ No

Is Cosentyx being prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

If Psoriatic arthritis:

Is the patient currently receiving Cosentyx intravenous or subcutaneous? ☐ Yes ☐ No

Has the patient already received at least 6 months of therapy with Cosentyx intravenous or subcutaneous? Please Note: Answer No if the patient has received less than 6 months of therapy or if the patient is restarting therapy with Cosentyx intravenous or subcutaneous. ☐ Yes ☐ No

Is Cosentyx being prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

When assessed by at least one objective measure, has the patient experienced a beneficial clinical response from baseline (prior to initiating Cosentyx intravenous or subcutaneous)? Please Note: Examples of standardized measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (for example, C-reactive protein, erythrocyte sedimentation rate). ☐ Yes ☐ No

Compared with baseline (prior to receiving Cosentyx intravenous or subcutaneous), has the patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths)? ☐ Yes ☐ No

Additional Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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