



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

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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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Active ankylosing spondylitis <input type="checkbox"/> Active psoriatic arthritis <input type="checkbox"/> Moderate to severe plaque psoriasis <input type="checkbox"/> Active Non-radiographic axial spondyloarthritis <input type="checkbox"/> Active enthesitis-related arthritis <input type="checkbox"/> Moderate to severe hidradenitis suppurativa (e.g., Hurley Stage II or III) <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information: Select if the requested medication is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other _____ Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For active ankylosing spondylitis, also answer the following: Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
For active psoriatic arthritis, also answer the following: Has the patient had an inadequate response, contraindication, or intolerance to methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For moderate to severe plaque psoriasis, also answer the following: Has the patient had an inadequate response, contraindication, or intolerance to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, calcipotriene, cyclosporine, acitretin, sulfasalazine, tazarotene, corticosteroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
For active non-radiographic axial spondyloarthritis or enthesitis-related arthritis, also answer the following: Has the patient had an inadequate response, contraindication, or intolerance to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					
For moderate to severe hidradenitis suppurativa, also answer the following: Has the patient had an inadequate response to, intolerance to, or contraindication to one or more of the following: oral or topical antibiotic therapy OR oral or injectable steroid therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No List _____					

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Office use only: Cosentyx_SouthDakotaMedicaid_2024January



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Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

- Titration or loading dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

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 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.