



TEXAS MEDICAID Clinical Edit Prior Authorization secukinumab (COSENTYX)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING

Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION

Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

STAR / STAR KIDS client (**Go to Step 3 - PDL PA Criteria Applies**)

OR CHIP / PERINATE client (**Go to Step 4**)

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

Yes (Go to Step 4 Question 1)

No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

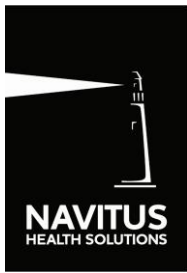
Yes (Go to Step 4 Question 1)

No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

Yes (Go to Step 4 Question 1)

No (Deny)



STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of ONE (1) of the following in the last 730 days?

- ankylosing spondylitis (AS)
- psoriatic arthritis (PsA)
- moderate to severe plaque psoriasis (Ps)
- non-radiographic axial spondyloarthritis

Yes (Go to #2)

No (Deny)

2. Is the client greater than or equal to (\geq) 18 years of age?

Yes (Go to #3)

No (Deny)

3. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

Yes (Deny)

No (Approve – 365 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.