Mass General Brigham
Health Plan

Cosentyx (secukinumab) Vial
Effective 08/12/2024

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☐ Pharmacy Benefit ☒ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical and Specialty Medications** All Plans | Phone: 877-519-1908 | Fax: 855-540-3693		
	Non-Specialty Medications All Plans | Phone: 800-711-4555 | Fax: 844-403-1029		
Exceptions	N/A		

Overview
Cosentyx (secukinumab) is an interleukin-17A (IL-17A) antagonist, available as an intravenous infusion. It is only FDA approved for active psoriatic arthritis in adults, and active ankylosing spondylitis in adults, including non-radiographic axial spondyloarthritis.

Coverage Guidelines
Authorization may be granted for members when all the following criteria are met:

Ankylosing Spondylitis or Non-radiographic axial spondyloarthritis

1. Diagnosis of ONE of the following:
    a. ankylosing spondylitis
    b. non-radiographic axial spondyloarthritis
2. Inadequate response or adverse reaction to TWO or contraindication to ALL NSAIDs*
3. Inadequate response or adverse reaction to ONE or contraindication to ALL anti-TNF agents that are FDA-approved for ankylosing spondylitis
4. Inadequate response, adverse reaction, or contraindication to Taltz®
5. Appropriate dosing

*If a member has tried biologic therapy and trial with an NSAID has not been documented, the trial may be bypassed

Psoriatic arthritis (PsA)

1. Diagnosis of psoriatic arthritis
2. Inadequate response, adverse reaction, or contraindication to Stelara® and Taltz®
3. Inadequate response or adverse reaction to ONE or contraindication to ALL anti-TNF agents that are FDA-approved for psoriatic arthritis
4. Appropriate dosing

SAPHO (Synovitis-acnepustulosis-hyperostosisosteitis) Syndrome

1. Diagnosis of SAPHO (synovitis-acne-pustulosis-hyperostosisosteitis) syndrome
2. Inadequate response or adverse reaction to ONE or contraindication to ALL NSAIDs
3. Inadequate response or adverse reaction to ONE or contraindication to ALL systemic corticosteroids

Requests for more frequent or higher doses may be approved if documentation of ALL of the following is provided:

1. Severe disease
2. Inadequate response or adverse reaction to ONE or contraindication to ALL other injectable biologic which is FDA-approved for the requested indication
3. Partial response to FDA-approved dosing of current biologic therapy
4. Prescriber is a specialist or consult notes for the requested indication from a specialist are provided

Continuation of Therapy

- For diagnosis of ankylosing Spondylitis, non-radiographic axial spondyloarthritis, or psoriatic arthritis: Resubmission by prescriber will infer a positive response to therapy.

- For diagnosis of SAPHO or requests for more frequency/higher doses, prescriber must provide documentation of a positive response to therapy.

Limitations

1. Initial approvals will be granted for:
    a. SAPHO: 3 months
    b. More frequent/higher doses requests: 3 months
    c. All other indications: 6 months
2. Reauthorizations will be granted for 12 months

References

Cosentyx® [package insert]. East Hanover (NJ): Novartis, Inc.; 2023 Nov.

Review History

07/10/24 – Created for P&T. Intravenous formulation will be available through medical benefit only. Adopted MH criteria from Targeted Immunomodulators guideline. Effective 8/12/24