JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP098
		Effective Date	01/15/2025
		Approval Date	07/17/2024
	Subject **Cosentyx IV**	*Supersedes Date*	N/A
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Cosentyx intravenous

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I. POLICY

A. Cosentyx intravenous (secukinumab) will require prior authorization for medical benefit coverage to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. Cosentyx intravenous may be approved for patients who meet the following:
   1. **Psoriatic arthritis (PsA)**
      a. Patient is 18 years of age or older
      b. Documentation has been submitted showing all of the following:
         I. Diagnosis of active psoriatic arthritis
         II. One of the following:
            i. Patient has previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for PsA
            ii. Patient meets either of the following conditions:
               A. Patient has mild to moderate disease and meets one of the following:
                  1. Patient has had inadequate response to an optimally dosed regimen with methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)
                  2. Patient has an intolerance or contraindication to methotrexate, leflunomide, or another conventional synthetic drug
                  3. Patient has any of the following contraindications to methotrexate, leflunomide, or another conventional synthetic drug:
                     a. Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
                     b. Drug interaction
                     c. Risk of treatment-related toxicity
                     d. Pregnancy or currently planning pregnancy
                     e. Breastfeeding

f. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
g. Hypersensitivity
h. History of intolerance or adverse event

4. Patient has enthesitis or predominantly axial disease

B. Patient has severe disease

2. **Ankylosing spondylitis (AS)**
   a. Patient is 18 years of age or older
   b. Documentation has been submitted showing all the following
      I. Diagnosis of active ankylosing spondylitis
      II. One of the following:
         i. Patient has previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for AS
         ii. Patient meets one of the following:
            A. Patient has had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs)
            B. Patient has intolerance or contraindication to two or more NSAIDs
3. **Non-radiographic axial spondyloarthritis (nr-axSpA)**
   a. Patient is 18 years of age or older
   b. Documentation has been submitted showing all of the following:
      I. Diagnosis of active non-radiographic axial spondyloarthritis
      II. One of the following:
         i. Patient has previously received a biologic or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for nr-axSpA
         ii. Patient meets one of the following:
            A. Patient has had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs)
            B. Patient has intolerance or contraindication to two or more NSAIDs

III. AUTHORIZATION PERIOD/LIMITATIONS

A. Initial approval will be limited to 12 months of therapy
B. Continuation of therapy may be approved in 12-month intervals with documentation showing the patient has achieved or maintained a positive clinical response to treatment evidenced by one of the following:
   1. PsA: Patient has low disease activity or improvement in signs and symptoms, and improvement in any of the following from baseline:
      a. Number of swollen joints
      b. Number of tender joints
      c. Dactylitis
      d. Enthesitis
      e. Axial disease
      f. Skin and/or nail involvement
   2. AS and nr-axSpA: Patient has low disease activity or improvement in signs and symptoms, and improvement in any of the following from baseline:
      a. Functional status

b. Total spinal pain
c. Inflammation (e.g., morning stiffness)

IV. EXCLUSIONS

A. Cosentyx will not be covered for the following:
   1. Any indications or uses that are not FDA-approved, or guideline-supported

V. RECOMMENDED DOSE

Please refer to the FDA-approved prescribing information, or clinical guidelines, for indication-specific dosing details.

VI. CODES

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Note: The following CPT/HCPCS codes are included below for informational purposes. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply member coverage or provider reimbursement. The member's specific benefit plan determines coverage.

Medication	HCPCS/CPT Code
Injection, secukinumab, intravenous, 1 mg	J3247

VII. REFERENCES

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VIII. APPROVALS

Signature on file at JHHP

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2024	Policy creation
01/15/2025	Removed prescriber specialty requirement

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