

Policy Name:	Cosentyx (secukinumab)	Policy#:	2332P
---------------------	-------------------------------	-----------------	--------------

Purpose of the Policy

The purpose of this policy is to define coverage criteria for Cosentyx (secukinumab)

Statement of the Policy

Health Alliance Medical Plans will approve the use of Cosentyx (secukinumab) under the specialty benefit if the following criteria are met.

Criteria

1. Coverage Criteria for Plaque Psoriasis

1.1 See [Plaque Psoriasis Immunomodulator Therapies](#) policy

2. Coverage Criteria for Ankylosing Spondylitis

2.1 See [Ankylosing Spondylitis Immunomodulator Therapies](#) policy

3. Coverage Criteria for Psoriatic Arthritis

3.1 See [Psoriatic Arthritis Immunomodulator Therapies](#) policy

4. Coverage Criteria for Nonradiographic Axial Spondyloarthritis

4.1 See [Nonradiographic Axial Spondyloarthritis Immunomodulators](#) policy

5. Coverage Criteria for enthesitis-related arthritis (ERA)

5.1 Diagnosis of active enthesitis-related arthritis

5.2 Age 4 years of age or older

5.3 Prescribed by or with a rheumatologist (musculoskeletal doctor)

5.4 Trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen)

6. Coverage Criteria for Hidradenitis Suppurativa

6.1 Diagnosis of Hidradenitis Suppurativa

6.2 Prescribed by or with a dermatologist (skin doctor)

6.3 Documented failure, intolerance, or contraindication to topical clindamycin therapy

6.4 Documented failure, intolerance, or contraindication to oral doxycycline, minocycline, or clindamycin therapy

6.5 Documented failure, intolerance, or contraindication to a covered adalimumab biosimilar

7. Exclusion Criteria

7.1 Inadequate response to initial or previous Cosentyx therapy

7.2 Patients with active infections, latent tuberculosis, or symptomatic or deteriorating congestive heart failure

7.3 Health Alliance does not cover concurrent therapy with other biologic DMARDs or other TNF blockers based upon the possible increased risk for infections and other potential pharmacological interactions

8. Approval Time

8.1 Initial: 12 Months

8.2 Reauthorization: 12 months with documentation of clinical benefit

CPT Codes	

HCPCS Codes	

References

1. Cosentyx [Prescribing Information]. East Hanover, New Jersey: Novartis; October 2023.
2. Onel KB, Horton DB, Lovell DJ, et al. 2021 American College of Rheumatology Guideline for the Treatment of Juvenile Idiopathic Arthritis: Therapeutic Approaches for Oligoarthritis, Temporomandibular Joint Arthritis, and Systemic Juvenile Idiopathic Arthritis. *Arthritis Rheumatol.* 2022 Apr;74(4):553-569.
3. Kimball AB, Jemec GBE, Alavi A, et al. Secukinumab in moderate-to-severe hidradenitis suppurativa (SUNSHINE and SUNRISE): week 16 and week 52 results of two identical, multicentre, randomised, placebo-controlled, double-blind phase 3 trials. *Lancet* 2023; 401:747.

Created Date: 04/01/15

Effective Date: 07/01/24

Posted to Website: 04/03/24

Revision Date: 04/03/24

DISCLAIMER

This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.