CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Cosentyx**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.

Office contact:		Provider specialty:	
Provider first name:		Provider last name:	
Provider phone #:	Provider fax #:	Provider NPI #:	
Patient name:	CCHP Member ID #:	Patient DOB:	Patient age:
Drug requested: **Brand** **Generic**	Strength:	Frequency:	Quantity dispensed (including units):

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** **No**

Diagnosis:

Please indicate place of administration:

Physician's office **Hospital/clinic** **Patient home** **Other**

Please provide hospital/facility name and address:
Name: ____________________
Phone #: ____________________
Address: ____________________
____

Will the drug be: (select one)
Billed medically using a JCODE
JCODE: ___________
Billed at a pharmacy

Please complete all of the following sections:

Please indicate disease severity: **Moderate** **Severe**

Date of most recent tuberculosis skin test:__________________ Result of tuberculosis skin test: **Positive** **Negative**

Does the member currently have evidence of infection?	**Yes** **No**
Is the member up to date with all immunizations according to current immunization guidelines?	**Yes** **No**
Is the member currently using another TNF-blocking or biologic agent in combination with Cosentyx? If yes, please provide name of medication: ____________________	**Yes** **No**

Plaque Psoriasis	Please indicate % Body Surface Area involvement: **Less than 5%** **Greater than or equal to 5%**	
	Does the member have plaque psoriasis on the palms, soles, head, neck or genitalia?	**Yes** **No**
	Has the member tried and failed phototherapy or photochemotherapy?	**Yes** **No**
Psoriatic Arthritis	Is the member's disease currently active?	**Yes** **No**
	Has the member tried and failed any NSAIDs for at least 2 weeks? **If yes, please provide drug name(s) and reason for discontinuation on page 2.**	**Yes** **No**
Ankylosing	Is the member's disease currently active?	**Yes** **No**
	Does the member have dominant **peripheral** disease?	**Yes** **No**

Spondylitis	Does the member have dominant **axial** disease?	**Yes** **No**
	Has the member tried and failed any NSAIDs for at least 4 weeks? **If yes, please provice drug name(s) and reason for discontinuation on page 2.**	**Yes** **No**

Please indicate past medication(s) tried and failed (including topical treatments):					
Medication name	**Start date**	**End date**	**Strength**	**Frequency**	**Reason for failure, discontinuation**
Methotrexate					
Cyclosporine					
Acitretin					
Sulfasalazine					
Leflunomide					
Humira**					
Enbrel**					
Non-Steroidal Anti-Inflammatory Drugs *(please provide names):*					
Other *(please provide names):*					

Please provide any additional information in the space below.

*** – Enbrel and Humira are the preferred subcutaneous TNF products for Chorus Community Health Plans*