

										
AETNA BETTER HEALTH® Coverage Policy/Guideline										
Name: Cosentyx	Page: 1 of 9									
Effective Date: 5/1/2025	Last Review Date: 4/2025									
Applies to:	<table border="0"> <tr> <td><input type="checkbox"/> Illinois</td> <td><input type="checkbox"/> Florida</td> <td><input checked="" type="checkbox"/> Florida Kids</td> </tr> <tr> <td><input type="checkbox"/> New Jersey</td> <td><input checked="" type="checkbox"/> Maryland</td> <td><input type="checkbox"/> Michigan</td> </tr> <tr> <td><input checked="" type="checkbox"/> Pennsylvania Kids</td> <td><input type="checkbox"/> Virginia</td> <td><input checked="" type="checkbox"/> Kentucky PRMD</td> </tr> </table>	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD
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Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Cosentyx under the patient's prescription drug benefit.

Description:

FDA-Approved Indications

- A. Moderate to severe plaque psoriasis (PsO) in patients 6 years of age and older who are candidates for systemic therapy or phototherapy
- B. Active psoriatic arthritis (PsA) in patients 2 years of age and older
- C. Adults with active ankylosing spondylitis (AS)
- D. Adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation
- E. Active enthesitis-related arthritis (ERA) in patients 4 years of age and older
- F. Adults with moderate to severe hidradenitis suppurativa (HS)

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Non-preferred: Cosentyx

Policy/Guideline:

Documentation for all indications:

The patient is unable to take THREE preferred products, where indicated, for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval.

THREE preferred products:

- A preferred adalimumab product OR Enbrel
- Two of the following:
 - A preferred ustekinumab product
 - Otezla
 - Rinvoq

Documentation:

A. Plaque psoriasis (PsO)

1. Initial requests



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 2 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

- i. Chart notes or medical record documentation of affected area(s) and body surface area (BSA) affected (if applicable).
 - ii. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation of decreased body surface area (BSA) affected and/or improvement in signs and symptoms.

B. Psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), and enthesitis-related arthritis (ERA), hidradenitis suppurativa

1. Initial requests: Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.
2. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialty:

This medication must be prescribed by or in consultation with one of the following:

- A. Plaque psoriasis: dermatologist
- B. Psoriatic arthritis and hidradenitis suppurativa: rheumatologist or dermatologist
- C. Ankylosing spondylitis, non-radiographic axial spondyloarthritis, and enthesitis-related arthritis: rheumatologist

Criteria for Initial Approval:

A. Plaque psoriasis (PsO)

1. Authorization of 12 months may be granted for members 6 years of age or older who have previously received a biologic or targeted synthetic drug indicated for the treatment of moderate to severe plaque psoriasis.
2. Authorization of 12 months may be granted for members 6 years of age or older for the treatment of moderate to severe plaque psoriasis when any of the following criteria is met:
 - i. Crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected.
 - ii. At least 10% of body surface area (BSA) is affected.
 - iii. At least 3% of body surface area (BSA) is affected and the member meets any of the following criteria:



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 3 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

- a. Member has had an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin.
- b. Member has a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin (see Appendix).

B. Psoriatic arthritis (PsA)

- I. Authorization of 12 months may be granted for members 2 years of age or older who have previously received a biologic or targeted synthetic drug indicated for active psoriatic arthritis.
- II. Authorization of 12 months may be granted for members 2 years of age or older for treatment of active psoriatic arthritis when either of the following criteria is met:
 - a. Member has mild to moderate disease and meets one of the following criteria:
 - i. Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
 - ii. Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix), or another conventional synthetic drug (e.g., sulfasalazine).
 - iii. Member has enthesitis or predominantly axial disease.
 - b. Member has severe disease.

C. Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)

1. Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis.
2. Authorization of 12 months may be granted for adult members for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis when any of the following criteria is met:
 - i. Member has had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs).
 - ii. Member has an intolerance or contraindication to two or more NSAIDs.

D. Enthesitis-related arthritis (ERA)

1. Authorization of 12 months may be granted for members 4 years of age or older who have previously received a biologic for treatment of active enthesitis-related arthritis.
2. Authorization of 12 months may be granted for members 4 years of age or older for treatment of active enthesitis-related arthritis when both of the following criteria are met:



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 4 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

- i. Member has active disease demonstrated by at least three active joints involved and at least one site of active enthesitis at baseline or documented by history.
- ii. Member meets either of the following:
 - a. Member has had an inadequate response to nonsteroidal anti-inflammatory drugs (NSAIDs), sulfasalazine, or methotrexate.
 - b. Member has an intolerance or contraindication to NSAIDs, sulfasalazine (e.g., porphyria, intestinal or urinary obstruction), and methotrexate (see Appendix).

E. Hidradenitis suppurativa

1. Authorization of 12 months may be granted for adult members who have previously received a biologic indicated for treatment of moderate to severe hidradenitis suppurativa.
2. Authorization of 12 months may be granted for adult members for treatment of moderate to severe hidradenitis suppurativa when either of the following is met:
 - i. Member has had an inadequate response to an oral antibiotic used for the treatment of hidradenitis suppurativa for at least 90 days (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines).
 - ii. Member has an intolerance or contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa.

Continuation of Therapy:

A. Plaque psoriasis (PsO)

Authorization of 12 months may be granted for all members 6 years of age or older (including new members) who are using the requested medication for moderate to severe plaque psoriasis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when either of the following is met:

1. Reduction in body surface area (BSA) affected from baseline
2. Improvement in signs and symptoms from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)

B. Psoriatic arthritis (PsA)

Authorization of 12 months may be granted for all members 2 years of age or older (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of swollen joints



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 5 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

2. Number of tender joints
3. Dactylitis
4. Enthesitis
5. Axial disease
6. Skin and/or nail involvement
7. Functional status
8. C-reactive protein (CRP)

C. Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for ankylosing spondylitis or non-radiographic axial spondyloarthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Functional status
2. Total spinal pain
3. Inflammation (e.g., morning stiffness)
4. Swollen joints
5. Tender joints
6. C-reactive protein (CRP)

D. Enthesitis-related arthritis (ERA)

Authorization of 12 months may be granted for all members 4 years of age or older (including new members) who are using the requested medication for active enthesitis-related arthritis and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when there is improvement in any of the following from baseline:

1. Number of flares
2. Number of joints with active arthritis (e.g., swelling, pain)
3. Number of joints with limited movement
4. Dactylitis
5. Enthesitis

E. Hidradenitis suppurativa

Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for moderate to severe hidradenitis suppurativa and who achieve or maintain a positive clinical response as evidenced by



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 6 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
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low disease activity or improvement in signs and symptoms of the condition when any of the following is met:

1. Reduction in abscess and inflammatory nodule count from baseline
2. Reduced formation of new sinus tracts and scarring
3. Decrease in frequency of inflammatory lesions from baseline
4. Reduction in pain from baseline
5. Reduction in suppuration from baseline
6. Improvement in frequency of relapses from baseline
7. Improvement in quality of life from baseline
8. Improvement on a disease severity assessment tool from baseline

Other Criteria:

For all indications: Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA])* within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

APPENDIX

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, Acitretin, or Leflunomide

1. Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
2. Drug interaction
3. Risk of treatment-related toxicity
4. Pregnancy or currently planning pregnancy
5. Breastfeeding
6. Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 7 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

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	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

7. Hypersensitivity
8. History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Approval:

Initial Approval: 12 months

Renewal Approval: 12 months

Quantity Level Limit:

Medication	Standard Limit	Exception Limit*	FDA-recommended dosing
Cosentyx (secukinumab): 75 mg/0.5 mL pre-filled syringe	1 syringe per 28 days	5 syringes per 28 days	Psoriatic arthritis (PsA)/Ankylosing spondylitis (AS)/Non-radiographic axial spondyloarthritis (NR-axSpA), adults: <ul style="list-style-type: none">• Loading doses (optional): 150 mg at weeks 0, 1, 2, 3, 4• Maintenance dose: 150 mg every 4 weeks• Continued active PsA/AS: 300 mg every 4 weeks Psoriatic arthritis, pediatric (2 years and older): <ul style="list-style-type: none">• ≥ 15 kg to < 50 kg: 75 mg at weeks 0, 1, 2, 3, and 4, then 75 mg every 4 weeks• ≥ 50 kg: 150 mg at weeks 0, 1, 2, 3, and 4, then 150 mg every 4 weeks
Cosentyx (secukinumab): 150 mg/mL pre-filled pen or syringe	1 pen/syringe per 28 days	5 pens/syringes per 28 days	
Cosentyx (secukinumab): 300 mg/2 mL pre-filled pen or syringe	1 pen/syringe per 28 days	5 pens/syringes per 28 days	



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 8 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:

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<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

Medication	Standard Limit	Exception Limit*	FDA-recommended dosing
Cosentyx (secukinumab): 300 mg dose carton containing (2) 150 mg/mL pre-filled pens or (2) 150 mg/mL pre-filled syringes	1 dose carton per 28 days	5 dose cartons per 28 days	<p>Plaque psoriasis, with or without coexistent psoriatic arthritis, adults:</p> <ul style="list-style-type: none">• Loading doses: 300 mg at weeks 0, 1, 2, 3, 4• Maintenance dose: 300 mg every 4 weeks (150 mg every 4 weeks may be acceptable) <p>Plaque psoriasis, pediatric (6 years and older):</p> <ul style="list-style-type: none">• < 50 kg: 75 mg at weeks 0, 1, 2, 3, and 4, then 75 mg every 4 weeks• ≥ 50 kg: 150 mg at weeks 0, 1, 2, 3, and 4, then 150 mg every 4 weeks <p>Enthesitis-Related Arthritis (4 years and older):</p> <ul style="list-style-type: none">• ≥ 15 kg to < 50 kg: 75 mg at weeks 0, 1, 2, 3, and 4, then 75 mg every 4 weeks• ≥ 50 kg: 150 mg at weeks 0, 1, 2, 3, and 4, then 150 mg every 4 weeks

*Exception limits apply to loading doses.

References:

1. Cosentyx [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; November 2023.
2. Menter A, Korman NJ, Elmetts CA, et al. Guidelines of care for the management of psoriasis and psoriatic arthritis. Section 6: Guidelines of care for the treatment of psoriasis and psoriatic arthritis: case-based presentations and evidence-based conclusions. *J Am Acad Dermatol*. 2011;65(1):137-174.
3. [Gossec L](#), Baraliakos X, Kerschbaumer A, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2019 update. *Ann Rheum Dis*. 2020;79(6):700-712.



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Cosentyx

Page: 9 of 9

Effective Date: 5/1/2025

Last Review Date: 4/2025

Applies to:	<input type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
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4. [McInnes IB, Mease PJ, Kirkham B](#), et al. Secukinumab, a human anti-interleukin-17A monoclonal antibody, in patients with psoriatic arthritis (FUTURE 2): a randomised, double-blind, placebo-controlled, phase 3 trial. *Lancet*. 2015;386(9999):1137-46.
5. Braun J, van den Berg R, Baraliakos, X et al. 2010 update of the ASAS/EULAR recommendations for the management of ankylosing spondylitis. *Ann Rheum Dis*. 2011;70:896-904.
6. [Ward MM, Deodhar A, Gensler LS](#), et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network Recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol*. 2019;71(10):1285-1299.
7. [Baeten D, Sieper J, Braun J](#), et al. Secukinumab, an Interleukin-17A Inhibitor, in Ankylosing Spondylitis. *N Engl J Med*. 2015;373(26):2534-48.
8. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol*. 2019;80(4):1029-1072.
9. Testing for TB Infection. Centers for Disease Control and Prevention. Retrieved on January 4, 2023 from: <https://www.cdc.gov/tb/topic/basics/risk.htm>.
10. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Arthritis Rheum*. 2018;71:5-32.
11. Weiss PF. Diagnosis and treatment of enthesitis-related arthritis. *Adolesc Health Med Ther*. 2012;2012(3):67-74.
12. Brunner HI, Foeldvari I, Alexeeva E, et al. Secukinumab in enthesitis-related arthritis and juvenile psoriatic arthritis: a randomised, double-blind, placebo-controlled, treatment withdrawal, phase 3 trial. *Ann Rheum Dis*. 2023 Jan;82(1):154-160.
13. Coates LC, Soriano ER, Corp N, et al. Group for Research and Assessment of Psoriasis and Psoriatic Arthritis (GRAPPA): updated treatment recommendations for psoriatic arthritis 2021. *Nat Rev Rheumatol*. 2022;18(8):465-479.
14. Menter A, Gelfand JM, Connor C, et al. Joint American Academy of Dermatology-National Psoriasis Foundation guidelines of care for the management of psoriasis with systemic nonbiologic therapies. *J Am Acad Dermatol*. 2020;82(6):1445-1486.
15. Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. *Ann Rheum Dis*. 2023;82:19-34.
16. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: A publication from the United States and Canadian Hidradenitis Suppurativa Foundations Part I: Diagnosis, evaluation, and the use of complementary and procedural management. *J Am Acad Dermatol*. 2019; 81(1): 76-90.
17. Alikhan A, Sayed C, Alavi A, et al. North American clinical management guidelines for hidradenitis suppurativa: A publication from the United States and Canadian Hidradenitis Suppurativa Foundations Part II: Topical, intralesional, and systemic medical management. *J Am Acad Dermatol*. 2019; 81(1): 91-101.