Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Cosentyx® (secukinumab)**

Effective: September 1, 2025

Guideline Type	☒ Prior Authorization ☒ Non-Formulary ☐ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Cosentyx (secukinumab) is an interleukin-17A antagonist indicated for:

Disease State	
Ankylosing Spondylitis	X
Hidradenitis Suppurativa	X
Enthesitis-related Arthritis	X
Non-radiographic Axial Spondyloarthritis	X
Plaque Psoriasis	X
Psoriatic Arthritis	X

Clinical Guideline Coverage Criteria

The plan may authorize coverage of Cosentyx for Members when **ALL** of the following criteria are met:

Ankylosing Spondylitis

1. Documented diagnosis of ankylosing spondylitis

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by or in consultation with a rheumatologist

AND

4. Documentation of **one (1)** of the following:
   a. Trial and failure of at least two of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category):
      i. Interleukin Antagonists: Bimzelx, Taltz
      ii. Janus Kinase Inhibitors: Rinvoq, Xeljanz
      iii. Tumor Necrosis Factor: Cimzia, Enbrel, Humira, Simponi
   b. Contraindication to all the following medications: Bimzelx, Taltz, Rinvoq, Xeljanz, Cimzia, Enbrel, Humira, Simponi

Enthesitis-related Arthritis

1. Documented diagnosis of enthesitis-related arthritis

AND

2. Patient is at least 4 years of age or older

AND

3. Prescribed by or in consultation with a rheumatologist

Hidradenitis Suppurativa

1. Documented diagnosis of hidradenitis suppurativa

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by or in consultation with a dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. Trial and failure with Humira AND Bimzelx
    b. Contraindication to Humira AND Bimzelx

Non-radiographical Axial Spondyloarthritis

1. Documented diagnosis of non-radiographic axial spondyloarthritis

AND

2. Patient is at least 18 years of age or older

AND

3. Prescribed by or in consultation with a rheumatologist

AND

4. Documentation of objective signs of inflammation

AND

5. Documentation of **one (1)** of the following:
    a. Trial and failure of all of the following medications: Bimzelx, Cimzia, Rinvoq, Taltz
    b. Contraindication to all of the following medications: Bimzelx, Cimzia, Rinvoq, Taltz

Plaque Psoriasis

1. Documented diagnosis of plaque psoriasis

AND

2. Patient is at least 6 years of age or older

AND

3. Prescribed by or in consultation with a dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. Trial and failure of at least two of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category):
        i. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, Yesintek
        ii. Phosphodiesterase 4 inhibitors: Otezla
        iii. Tumor Necrosis Factors: Cimzia, Enbrel, Humira
    b. Contraindication to all the following medications: Bimzelx, Skyrizi, Taltz, Tremfya, Yesintek, Otezla, Cimzia, Enbrel, Humira

Psoriatic Arthritis

1. Documented diagnosis of psoriatic arthritis

AND

2. Patient is at least 2 years of age or older

AND

3. Prescribed by or consultation with a rheumatologist or dermatologist

AND

4. Documentation of **one (1)** of the following:
    a. Trial and failure of at least two of the listed medications from each of the following therapeutic categories (only one medication is required if only one is available for a listed therapeutic category):

i. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, Yesintek
ii. Janus Kinase Inhibitors: Rinvoq, Xeljanz
iii. Phosphodiesterase 4 inhibitors: Otezla
iv. Selective T Cell Stimulators: Orencia
v. Tumor Necrosis Factors: Cimzia, Enbrel, Humira, Simponi

b. Contraindication to all the following medications: Bimzelx, Skyrizi, Taltz, Tremfya, Yesintek, Rinvoq, Xeljanz, Otezla, Orencia, Cimzia, Enbrel, Humira, and Simponi

Limitations

1. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response and will not be considered for prior authorization.

Codes

None

References

1. Cosentyx (secukinumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; March 2025.
2. 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.
3. Braun J, Davis J et al. First update of the international ASAS consensus statement for the use of anti-TNF agents in patients with ankylosing spondylitis. Ann Rheum Dis. 2006; 65(3):316-20.
4. 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;80:1029-72.
5. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. Arthritis Rheumatol. 2019;71(6):846-863.
6. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. Arthritis Rheumatol. 2019;71(1):5-32

Approval And Revision History

June 10, 2025: Reviewed by the Pharmacy & Therapeutics Committee.

Background, Product and Disclaimer Information

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.