

secukinumab (Cosentyx IV)

Commercial Medical Benefit Drug Policy

Place of Service

Office Administration

Home Health Administration

Outpatient Facility Infusion Administration

Infusion Center Administration

Drug Details

USP Category: IMMUNOLOGICAL AGENTS

Mechanism of Action: Interleukin-17 antagonist monoclonal antibody

HCPCS:

J3247:Injection, secukinumab, intravenous, 1 mg

How Supplied:

125 mg/5 mL solution in a single-dose vial

Condition(s) listed in policy (see coverage criteria for details)

- Ankylosing Spondylitis
- Non-Radiographic Axial Spondyloarthritis
- Psoriatic Arthritis

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Members with the following plans: **PPO, Direct Contract HMO, and when applicable, ASO, Shared Advantage, HMO (non-direct)** may be required to have their medication administered at a preferred site of service, including the home, a physician's office, or an independent infusion center not associated with a hospital.

For members that cannot receive infusions in the preferred home or ambulatory setting AND meet one of the following criteria points, drug administration may be performed at a hospital outpatient facility infusion center.

CRITERIA FOR HOSPITAL OUTPATIENT FACILITY ADMINISTRATION

MCG Care Guidelines, 19th edition, 2015

ADMINISTRATION OF COSENTYX IN THE HOSPITAL OUTPATIENT FACILITY SITE OF CARE
REQUIRES ONE OF THE FOLLOWING: (*Supporting Documentation must be submitted*)

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1. Patient is initiating on Cosentyx (covered for the first dose) or is being re-initiated on Cosentyx (covered for the first dose) after at least 6 months off therapy. *Subsequent doses will require medical necessity for continued use in the hospital outpatient facility site of care.*

Or

Additional clinical monitoring is required during administration as evidenced by one of the following:

2. Patient has experienced a previous severe adverse event on Cosentyx based on documentation submitted.
3. Patient continues to experience moderate to severe adverse events on the requested drug based on documentation submitted, despite receiving premedication such as acetaminophen, steroids, diphenhydramine, fluids, etc.
4. Patient is clinically unstable based on documentation submitted.
5. Patient is physically or cognitively unstable based on documentation submitted.

Coverage Criteria

The following condition(s) require Prior Authorization/Preservice.

Ankylosing Spondylitis

Meets medical necessity if all the following are met:

1. Prescribed by or in consultation with a rheumatologist
2. Not used in combination with other targeted immunomodulators
3. Meets ONE of the following:
 - a. Inadequate response with a trial of any two-prescription strength NSAIDs
 - b. Intolerance GI adverse events after a trial of a prescription strength NSAID in combination with a PPI
 - c. Unable to take NSAIDs due to history of GI bleed
4. Inadequate response or intolerable side effect with two BSC-preferred agents (adalimumab-aacf, Cosentyx SC, Enbrel, infliximab (Inflectra or Avsola), Rinvoq, and Xeljanz/Xeljanz XR), or contraindication to all preferred agents

Covered Doses:

- With a loading dosage: 6 mg/kg given intravenously (IV) at Week 0 as a loading dose, followed by 1.75 mg/kg given every 4 weeks thereafter (max. maintenance dose 300 mg per infusion).
- Without a loading dosage: 1.75 mg/kg given IV every 4 weeks (max. maintenance dose 300 mg per infusion).

Coverage Period:

Yearly based upon continued response

ICD-10:

M45.0-M45.9

Non-Radiographic Axial Spondyloarthritis

Meets medical necessity if all the following are met:

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1. Prescribed by or in consultation with a rheumatologist
2. One of the following:
 - a. Inadequate response with a trial of any two-prescription strength NSAIDs
 - b. Intolerance GI adverse events after a trial of a prescription strength NSAID in combination with a PPI
 - c. Unable to take NSAIDs due to history of GI bleed
3. Not being used with other targeted immunomodulators (e.g. anti-TNFs, interleukin inhibitors, JAK inhibitors)
4. Inadequate response or intolerable side effect with two preferred agents (e.g., Cimzia, Cosentyx SC, and Rinvoq), or contraindication to all preferred agents

Covered Doses:

- With a loading dosage: 6 mg/kg given intravenously (IV) at Week 0 as a loading dose, followed by 1.75 mg/kg given IV every 4 weeks thereafter (max. maintenance dose 300 mg per infusion).
- Without a loading dosage: 1.75 mg/kg given IV every 4 weeks (max. maintenance dose 300 mg per infusion).

Coverage Period:

Yearly based upon continued response

ICD-10:

M48.8X1-M48.8X9

Psoriatic Arthritis

Meets medical necessity if all the following are met:

1. Prescribed by or in consultation with a rheumatologist
2. Inadequate response, intolerance, or contraindication to one or more disease modifying anti-rheumatic drugs (DMARDs) or has a medical reason why methotrexate, sulfasalazine, and leflunomide cannot be used
3. Not being used in combination with other targeted immunomodulators
4. Inadequate response, or intolerable side effect with two preferred agents (e.g., adalimumab-aacf, Cosentyx SC, Enbrel, infliximab (e.g., Avsola, Inflectra), Otezla, Rinvoq, Skyrizi SC, Yesintek SC, Tremfya SC, and Xeljanz/Xeljanz XR), or contraindication to all preferred agents

Covered Doses:

- With a loading dosage: 6 mg/kg given intravenously (IV) at Week 0 as a loading dose, followed by 1.75 mg/kg every 4 weeks thereafter (max. maintenance dose 300 mg per infusion).
- Without a loading dosage: 1.75 mg/kg given IV every 4 weeks (max. maintenance dose 300 mg per infusion).

Coverage Period:

Yearly based upon continued response

ICD-10:

L40.50-L40.59

References

1. AHFS. Available by subscription at <http://www.lexi.com>
2. Cosentyx (secukinumab) Prescribing Information. Novartis, East Hanover, NJ. September 2024.
3. DrugDex. Available by subscription at <http://www.micromedexsolutions.com/home/dispatch>
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. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation Guideline for the Treatment of Psoriatic Arthritis. *Journal of Psoriasis and Psoriatic Arthritis*. 2019; 4(1): 31-58.
6. Ward MM, Deodhar A, Gensler LS, Dubreuil M. et al. 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; 71:1599–613

Review History

Date of Last Annual Review: 3Q2025

Changes from previous policy version:

- no clinical changes

Blue Shield of California Medication Policy to Determine Medical Necessity

Reviewed by P&T Committee