blue california
Promise Health Plan

secukinumab (Cosentyx IV)

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 (AS)
- Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
- Psoriatic Arthritis (PsA)

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the California Code of Regulations (CCR), Title 22, Section 51303 and 51313 must be met.

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.

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

Ankylosing Spondylitis (AS)
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 (i.e., anti-TNFs, interleukin inhibitors)
3. 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. Patient has had an inadequate response or intolerable side effect with preferred infliximab products (Avsola, Inflectra, and Renflexis), or contraindication to all infliximab products

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:
M45.0-M45.9

Non-Radiographic Axial Spondyloarthritis (nr-axSpA)
Meets medical necessity if all the following are met:

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)

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 (PsA)

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 (e.g. anti-TNFs, interleukin inhibitors, JAK inhibitors, Otezla)
4. Patient has had an inadequate response or intolerable side effect with preferred infliximab products (Avsola, Inflectra, and Renflexis), or contraindication to all infliximab products

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 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:

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: 2Q2024

Changes from previous policy version:

- Added HCPCS J3247, effective 7/1/2024

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee