Harvard Pilgrim Health Care | TUFTS Health Plan

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

Effective: July 1, 2026

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

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

Initial Authorization Criteria

1. Documented diagnosis of active ankylosing spondylitis

AND

2. Patient is at least 12 years of age or older

AND

3. Prescribed by a rheumatologist

AND

4. Documentation of history of failure to **one (1)** prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date and duration of trial)*

AND

5. Documentation of history of failure to **two (2)** 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), unless contraindicated *(Note: document drugs, dates, and duration of trials)*:
   a. Interleukin Antagonists: Bimzelx, Taltz
   b. Janus Kinase Inhibitors: Rinvoq, Xeljanz
   c. Tumor Necrosis Factor: Cimzia, Enbrel, Simlandi, Simponi

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a

targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of active ankylosing spondylitis

AND

3. Patient is at least 12 years of age or older

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Enthesitis-related Arthritis

Initial Authorization Criteria

1. Documented diagnosis of active enthesitis-related arthritis

AND

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

AND

3. Prescribed by a rheumatologist

AND

4. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been established on the requested medication for at least 12 months

AND

2. Documented diagnosis of active enthesitis-related arthritis

AND

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

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Hidradenitis Suppurativa

Initial Authorization Criteria

1. Documented diagnosis of moderate to severe hidradenitis suppurativa

AND

2. Documentation of Hurley Stage II or III disease

AND

3. Patient is at least 12 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Documentation of history of failure to **three (3)** of the following conventional treatments, unless contraindicated or clinically significant adverse effects are experienced *(Note: document drugs, dates, and duration of trials)*:
    a. Local hygiene and ordinary hygiene
    b. Weight reduction in patients who are obese

c. Use of ordinary saps and antiseptic and antiperspirant agents (e.g., aluminum chloride hexahydrate)
d. Application of warm compresses with sodium chloride solution or Burrow's solution
e. Laser hair removal
f. Cessation of cigarette smoking
g. Medical anti-inflammatory or antiandrogen therapy such as oral or topical antibiotics, intralesional triamcinolone, spironolactone, or finasteride

AND

6. Documentation of history of failure with **both** of the following, unless contraindicated *(Note: document dates and duration of trials)*:
   a. Bimzelx
   b. Simlandi

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of moderate to severe hidradenitis suppurativa

AND

3. Patient is at least 12 years of age or older

AND

4. Prescribed by a dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined as an improvement from baseline in at least **one (1)** objective measure (e.g., Hurley staging, Sartorius score, Physician Global Assessment, Hidradenitis Suppurativa Severity Index)

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of hidradenitis suppurativa such as decreased pain or drainage of lesions, nodules, or cysts

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Non-radiographical Axial Spondyloarthritis

Initial Authorization Criteria

1. Documented diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation

AND

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

AND

3. Prescribed by a rheumatologist

AND

4. Documentation of history of failure to **one (1)** prescription strength non-steroidal anti-inflammatory drug (e.g., celecoxib, diclofenac, ibuprofen, naproxen, meloxicam), unless contraindicated or clinically significant adverse effects are experienced *(Note: document drug, date and duration of trial)*

AND

5. Documentation of history of failure to **two (2)** 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), unless contraindicated *(Note: document drug, date and duration of trial)*:
   a. Interleukin Antagonists: Bimzelx, Taltz
   b. Janus Kinase Inhibitor: Rinvoq
   c. Tumor Necrosis Factors: Cimzia

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least 12 months

AND

2. Documented diagnosis of active non-radiographic axial spondyloarthritis with objective signs of inflammation

AND

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

AND

4. Prescribed by a rheumatologist

AND

5. Documentation of clinically significant improvement or stabilization in clinical signs and symptoms of disease as determined by the prescriber

AND

6. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Plaque Psoriasis

Initial Authorization Criteria

1. Documented diagnosis of moderate to severe plaque psoriasis

AND

2. Documentation of **one (1)** of the following:
    a. Greater than or equal to 3% body surface area involvement
    b. Severe scalp psoriasis
    c. Palmoplantar, facial, or genital involvement

AND

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

AND

4. Prescribed by a dermatologist

AND

5. Documentation of failure to a minimum three (3) month supply of at least **one (1)** of the following traditional systemic agents, unless contraindicated or clinically significant adverse effects are experienced: methotrexate, cyclosporine, acitretin, or phototherapy *(Note: document drug, date and duration of trial)*

AND

6. Documentation of history of failure to **two (2)** 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), unless contraindicated *(Note: document drugs, dates and duration of trials)*:
    a. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, or Yesintek or Starjemza
    b. Phosphodiesterase 4 inhibitors: Otezla
    c. Tumor Necrosis Factors: Cimzia, Enbrel, Simlandi

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of moderately to severe plaque psoriasis

AND

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

AND

4. Prescribed by a dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined as reduction in body surface area affected by plaque psoriasis from baseline

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of plaque psoriasis such as itching, redness, flaking, scaling, burning, cracking, or pain

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Psoriatic Arthritis

Initial Authorization Criteria

1. Documented diagnosis of active psoriatic arthritis

AND

2. Documentation of **one (1)** of the following:
    a. Actively inflamed joints
    b. Dactylitis
    c. Enthesitis
    d. Axial disease
    e. Active skin and/or nail involvement

AND

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

AND

4. Prescribed by a rheumatologist or dermatologist

AND

5. Documentation of failure to a minimum three (3) month supply of at least **one (1)** disease-modifying anti-rheumatic drug (e.g., methotrexate, sulfasalazine, cyclosporine), unless contraindicated or clinically significant adverse effects are experienced (*Note: document drug, date and duration of trial*)

AND

6. Documentation of history of failure to **two (2)** 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), unless contraindicated *(Note: document drugs, dates and duration of trials)*:
    a. Interleukin Antagonists: Bimzelx, Skyrizi, Taltz, Tremfya, or Yesintek or Starjemza
    b. Janus Kinase Inhibitors: Rinvoq, Xeljanz
    c. Phosphodiesterase 4 inhibitors: Otezla
    d. Selective T Cell Stimulators: Orencia
    e. Tumor Necrosis Factors: Cimzia, Enbrel, Simlandi, Simponi

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Reauthorization Criteria

1. Documentation the patient has been receiving the requested medication for at least six (6) months

AND

2. Documented diagnosis of active psoriatic arthritis

AND

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

AND

4. Prescribed by a rheumatologist or dermatologist

AND

5. Submission of medical charts documenting the patient experienced a beneficial clinical response defined improvement from baseline in at least **one (1)** of the following:
    a. Body surface area affected by psoriatic arthritis
    b. Total active (swollen and tender) joint count

AND

6. Submission of medical charts documenting that compared to baseline, the patient has experienced an improvement in at least one symptom of psoriatic arthritis such as joint pain, morning stiffness, fatigue, joint or tendon sheath swelling

AND

7. Documentation the patient is not receiving the requested medication in combination with another biologic drug or with a targeted synthetic oral small molecule drug

Limitations

1. Members who have already initiated the requested medication using samples, free goods, similar offerings, or self-paying for the medication directly do not qualify for an established clinical response and should be reviewed against initial approval

criteria.
2. For ankylosing spondylitis, enthesitis-related arthritis, and non-radiographic axial spondyloarthritis, authorizations will be provided in 12-month intervals. A patient who has received less than 12 months of therapy or who is restarting therapy with the requested drug is reviewed under Initial Authorization Criteria.
3. For hidradenitis suppurativa, plaque psoriasis and psoriatic arthritis, initial approval will be authorized for six (6) months. Reauthorization will be provided in 12-month intervals. A Member who has received less than six (6) months of therapy or who is restarting therapy with the requested drug is reviewed under Initial Authorization Criteria.
4. Members new to the plan stable on the requested medication should be reviewed against Initial Authorization Criteria.

Codes

None

References

1. Cosentyx (secukinumab) [prescribing information]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2026.
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.

- October 14, 2025: Provider requirements no longer allow with in consultation with the specialist. Added coverage criteria to prevent duplicative targeted immunomodulator therapy. For all indications except enthesitis-related arthritis, added non-biologic prerequisites. Updated biologic prerequisite language (no change in prerequisites). For hidradenitis suppurativa, plaque psoriasis and psoriatic arthritis, initial approvals limited to 6 months with annual reauthorization coverage criteria added. For plaque psoriasis and psoriatic arthritis added disease severity requirements. For ankylosing spondylitis, enthesitis-related arthritis, and non-radiographic axial spondyloarthritis approvals limited to 12 months with reauthorization criteria added (eff 1/1/26).
- December 9, 2025: Replaced Humira with Simlandi as Simlandi is the preferred adalimumab product (eff 3/1/26).
- June 9, 2026: Updated age requirements in ankylosing spondylitis and hidradenitis suppurativa to at least 12 years of age. Added Starjemza as a prerequisite for plaque psoriasis and psoriatic arthritis to support the updated ustekinumab strategy – Yesintek and Starjemza are the preferred ustekinumab products. Administrative update to the limitation statement to include members initiated on the requested medication by self-paying for the medication directly do not qualify for established clinical response and should be reviewed against initial approval criteria. Administrative update to remove CareLink from Medical Necessity Guideline template. (eff 7/1/26).

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.