Neighborhood Health Plan OF RHODE ISLAND™
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Cosentyx (secukinumab) (Intravenous)

Effective Date: 07/01/2024
Review Date: 05/01/2024, 1/22/2025, 08/17/2026
Scope: Medicaid, Commercial, Medicare

I. Length of Authorization

Coverage will be provided for 6 months and may be renewed for 12 months.

II. Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- Cosentyx 125 mg single-dose vial for intravenous infusion:
  - Loading: 6 vials at week 0
  - Maintenance: 3 vials every 28 days

B. Max Units (per dose and over time) [HCPCS Unit]:

Indication	Max Dose/Units
Psoriatic Arthritis, Ankylosing Spondylitis, and Non-Radiographic Axial Spondylarthritis	Intravenous Administration: • Loading: 750mg/units at weeks 0 • Maintenance:375mg/units every 28 days

III. Summary of Evidence:

Cosentyx IV (secukinumab) is a human interleukin-17A antagonist indicated for the treatment of adult patients with psoriatic arthritis (PsA), ankylosing spondylitis (AS), and non-radiographic axial spondyloarthritis (nr-axSpA). The effectiveness of intravenous Cosentyx in the treatment of adult patients with active PsA, AS and active nr-axSpA was extrapolated from the established effectiveness of subcutaneous Cosentyx in adult patients based on pharmacokinetic exposure. Cosentyx for IV administration is the first available IV treatment option approved for adults with PsA, AS, and nr-axSpA. Cosentyx IV is the first and only treatment in an IV formulation that targets and blocks interleukin-17A (IL-17A) and is the only IV non-tumor necrosis factor alpha option for these indications.

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IV. Initial Approval Criteria[1]

Coverage is provided in the following conditions:

Medicare members who have previously received this medication within the past 365 days are not subject to Step Therapy Requirements

- Submission of member's chart or medical record is required, documenting medical necessity based on the criteria corresponding to the applicable indication; AND
- Physician has assessed baseline disease severity utilizing an objective measure/tool; AND
- Member will not receive live vaccines during therapy; AND
- Member is free of any clinically important active infection, including clinically important localized infections; AND
- Member has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment and will receive ongoing monitoring for presence of TB during treatment; AND
- Cosentyx will not be used concomitantly with an injectable biologic response modifier including TNF-inhibitors (e.g., adalimumab (e.g., Hadlima), Enbrel (etanercept), infliximab (e.g., Inflectra), etc.) and IL-inhibitors including ustekinumab (e.g., Stelara, Otulfi, Selarsdi, Steqeyma, and Yesintek), Tremfya (guselkumab), Icotyde (icotrokinra), Ilumya (tildrakizumab), Skyrizi (risankizumab), Bimzelx (bimekizumab), etc.) or other oral non-biologic agent (e.g., Otezla (apremilast), tofacitinib (Xeljanz), Olumiant (baricitinib), Rinvoq (upadacitinib), etc.); AND
- If the member is requesting therapy with Cosentyx IV for loading dose the provider must submit medical rationale for why the member cannot be initiated at the IV maintenance dose.
- Documentation has been submitted of member's weight and prescribed dose, and 1.75mg/kg maintenance dose every 4 weeks has been optimized to reduce drug waste and allow for more efficient vial size utilization.

Moderately to severely active adult psoriatic arthritis (PsA) † [1,12,28,35,44,45]

- Member is 18 years of age or older: AND
- Cosentyx is prescribed by, or in consultation with, a specialist in dermatology or rheumatology; AND
- Member has documented moderate to severe active disease; AND
- Documentation has been submitted indicating one of the following criteria:
    - Member has mild to moderate disease and meets one of the following criteria:

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        - Member has had an inadequate response, intolerance, or contraindication to methotrexate or another conventional synthetic DMARD (e.g., leflunomide, sulfasalazine, etc.); OR
        - Member has enthesitis or predominantly axial disease; OR
    - Member has severe disease; AND
- Documentation has been submitted that the member has had an inadequate response, intolerance or contraindication to at least a 3-month trial of adalimumab AND at least a 6-month trial of ustekinumab at maximum tolerated doses

Active ankylosing spondylitis (AS) † [1,11,30,46]

- Member is 18 years of age or older; AND
- Cosentyx is prescribed by, or in consultation with, a specialist in rheumatology; AND
- Member has documented active disease; AND
- Documentation has been submitted of all of the following:
    - Member has had an inadequate response, intolerance, or contraindication to at least TWO (2) NSAIDs; AND
    - Member has had an inadequate response, intolerance or contraindication to at least a 3-month trial of adalimumab at maximum tolerated doses

Active non-radiographic axial spondyloarthritis (nr-axSpA) † [1,30,46]

- Member is 18 years of age or older; AND
- Cosentyx is prescribed by, or in consultation with, a specialist in rheumatology; AND
- Member has documented active disease with objective signs of inflammation noted by an elevation of C-reactive protein (CRP) above the upper limit of normal and/or sacroiliitis on MRI and member is without definitive radiographic evidence of structural damage on sacroiliac joints; AND
- Documentation has been submitted that the member meets all of the following criteria:
    - Member has had an inadequate response, intolerance, or contraindication to at least TWO (2) NSAIDs; AND
    - Member has had an inadequate response, intolerance or contraindication to at least a 3-month trial of adalimumab at maximum tolerated doses.

† FDA Approved Indication(s); ‡ Compendia Recommended Indication; Φ Orphan Drug

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V. Renewal Criteria

Moderately to severely active psoriatic arthritis (PsA)

- Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active psoriatic arthritis and who achieve or maintain 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:
    - Number of swollen joints
    - Number of tender joints
    - Dactylitis
    - Enthesitis
    - Axial disease
    - Skin and/or nail involvement
    - Functional status
    - C-reactive protein (CRP); AND
- Documentation has been submitted of member's weight and prescribed dose, and 1.75mg/kg maintenance dose every 4 weeks has been optimized to reduce drug waste and allow for more efficient vial size utilization.

Active ankylosing spondylitis (AS) and non-radiographic axial spondylarthritis (nr-axSpA)

- Authorization of 12 months may be granted for all members (including new members) who are using the requested medication for active ankylosing spondylitis or non-radiographic axial spondyloarthritis and who achieve or maintain positive clinical response with the requested medication 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:
    - Functional status
    - Total spinal pain
    - Inflammation (e.g., morning stiffness)
    - Swollen joints
    - Tender joints
    - C-reactive protein (CRP); AND
- Documentation has been submitted of member's weight and prescribed dose, and 1.75mg/kg maintenance dose every 4 weeks has been optimized to reduce drug waste and allow for more efficient vial size utilization.

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VI. Dosage/Administration

Indication	Dosing
Ankylosing Spondylitis	With loading dose: • 6 mg/kg by intravenous infusion at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter Without a loading dose: • 1.75 mg/kg by intravenous infusion every 4 weeks **Note:** Cosentyx may be administered with or without a loading dose for this indication. Total doses exceeding 300 mg per infusion are not recommended for the 1.75 mg/kg maintenance dose in adults with AS.
Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	With loading dose: • 6 mg/kg by intravenous infusion at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter Without a loading dose: • 1.75 mg/kg by intravenous infusion every 4 weeks **Note**: Cosentyx may be administered with or without a loading dose for this indication. Total doses exceeding 300 mg per infusion are not recommended for the 1.75 mg/kg maintenance dose in adults with nr-axSpA.
Psoriatic Arthritis	With loading dose: • 6 mg/kg by intravenous infusion at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter Without a loading dose: • 1.75 mg/kg by intravenous infusion every 4 weeks **Note:** Cosentyx may be administered with or without a loading dose for ADULT patients for this indication. Total doses exceeding 300 mg per infusion are not recommended for the 1.75 mg/kg maintenance dose in adults with PsA.

VII. Billing Code/Availability Information

HCPCS Code(s):

J3247: Injection, secukinumab, intravenous, 1 mg

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VIII. References

1. Cosentyx [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; April 2026. Accessed June 2026.
2. Menter A, Korman NJ, Elmets 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, Smolen JS, Ramiro S, et al. European League Against Rheumatism (EULAR) recommendations for the management of psoriatic arthritis with pharmacological therapies: 2015 update. *Ann Rheum Dis.* 2016;75(3):499-510.
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, Akl EA, et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2015: 10.1002/art.39298. [Epub ahead of print].
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.

Appendix 2 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD), Local Coverage Articles (LCAs) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/search.aspx. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCA/LCD): N/A

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Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	**Applicable State/US Territory**	**Contractor**
E (1)	CA, HI, NV, AS, GU, CNMI	Noridian Healthcare Solutions, LLC
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC
5	KS, NE, IA, MO	Wisconsin Physicians Service Insurance Corp (WPS)
6	MN, WI, IL	National Government Services, Inc. (NGS)
H (4 & 7)	LA, AR, MS, TX, OK, CO, NM	Novitas Solutions, Inc.
8	MI, IN	Wisconsin Physicians Service Insurance Corp (WPS)
N (9)	FL, PR, VI	First Coast Service Options, Inc.
J (10)	TN, GA, AL	Palmetto GBA, LLC
M (11)	NC, SC, WV, VA (excluding below)	Palmetto GBA, LLC
L (12)	DE, MD, PA, NJ, DC (includes Arlington & Fairfax counties and the city of Alexandria in VA)	Novitas Solutions, Inc.
K (13 & 14)	NY, CT, MA, RI, VT, ME, NH	National Government Services, Inc. (NGS)
15	KY, OH	CGS Administrators, LLC

Policy Rationale:

Cosentyx was reviewed by the Neighborhood Health Plan of Rhode Island Pharmacy & Therapeutics (P&T) Committee. Neighborhood adopted the following clinical coverage criteria to ensure that its members use Cosentyx according to Food and Drug Administration (FDA) approved labeling and/or relevant clinical literature. Neighborhood worked with network prescribers and pharmacists to draft these criteria. These criteria will help ensure its members are using this drug for a medically accepted indication, while minimizing the risk for adverse effects and ensuring more cost-effective options are used first, if applicable and appropriate. For Medicare members, these coverage criteria will only apply in the absence of National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria. Neighborhood will give individual consideration to each request it reviews based on the information submitted by the prescriber and other information available to the plan.

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