UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1152-14
Program	Prior Authorization/Notification
Medication	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen
P&T Approval Date	2/2015, 3/2016, 3/2017, 3/2018, 2/2019, 2/2020, 7/2020, 7/2021, 2/2022, 2/2023, 7/2023, 1/2024, 1/2025, 1/2026
Effective Date	4/1/2026

1. Background:

Cosentyx (secukinumab) is a human interleukin-17A antagonist indicated for the treatment of moderate to severe plaque psoriasis in patients 6 years and older who are candidates for systemic therapy or phototherapy, active psoriatic arthritis (PsA) in patients 2 years of age and older, adults with active ankylosing spondylitis (AS) or non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation, active enthesitis-related arthritis (ERA) in patients 4 years of age and older, and adults with moderate to severe hidradenitis (HS).

2. Coverage Criteria[a]:

A. Plaque Psoriasis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe plaque psoriasis

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Ilumya (tildrakizumab), Olumiant (baricitinib), Otezla (apremilast), Simponi (golimumab), Orencia (abatacept), Rinvoq (upadacitinib), Siliq (brodalumab), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)] for treatment of the same indication.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Ilumya (tildrakizumab), Olumiant (baricitinib), Otezla (apremilast), Simponi (golimumab), Orencia (abatacept), Rinvoq (upadacitinib), Siliq (brodalumab), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz (tofacitinib)] for treatment of the same indication.

Authorization will be issued for 12 months.

B. Psoriatic Arthritis

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of active psoriatic arthritis

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Otezla (apremilast), Rinvoq (upadacitinib), Simponi (golimumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), Xeljanz/Xeljanz XR (tofacitinib)] for treatment of the same indication.

Authorization will be issued for 12 months.

C. Ankylosing Spondylitis or Non-radiographic Axial Spondyloarthritis

1. **Initial Authorization**

   a. **Cosentyx** will be approved based on **both** of the following criteria:

      (1) Diagnosis of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis

      -AND-

      (2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication.

      Authorization will be issued for 12 months.

2. **Reauthorization**

   a. **Cosentyx** will be approved based on **both** of the following criteria:

      (1) Documentation of positive clinical response to Cosentyx therapy

      -AND-

      (2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx), Cimzia (certolizumab), Enbrel (etanercept), Olumiant (baricitinib), Orencia (abatacept), Simponi (golimumab), Rinvoq (upadacitinib), Taltz (ixekizumab), Xeljanz (tofacitinib)] for treatment of the same indication.

   Authorization will be issued for 12 months.

D. Enthesitis-Related Arthritis

1. **Initial Authorization**

   a. **Cosentyx** will be approved based on **both** of the following criteria:

      (1) Diagnosis of active enthesitis-related arthritis

      -AND-

      (2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)] for treatment of the same indication.

      Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Cimzia (certolizumab), Enbrel (etanercept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz (tofacitinib)] for treatment of the same indication.

Authorization will be issued for 12 months.

E. Hidradenitis Suppurativa (HS)

1. **Initial Authorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Diagnosis of moderate to severe hidradenitis suppurativa

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx)] for treatment of the same indication.

Authorization will be issued for 12 months.

2. **Reauthorization**

a. **Cosentyx** will be approved based on **both** of the following criteria:

(1) Documentation of positive clinical response to Cosentyx therapy.

-AND-

(2) Patient is not receiving Cosentyx in combination with another systemic targeted immunomodulator [e.g., adalimumab, Bimzelx (bimekizumab-bkzx)] for treatment of the same indication.

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits and/or Step Therapy may be in place.

4. Reference:

1. Cosentyx [package insert]. East Hanover, NJ. Novartis Pharmaceuticals Corp.; August 2025.

Program	Prior Authorization/Notification - Cosentyx (secukinumab)
Change Control	
2/2015	New program.
3/2016	Annual review. Updated background information and clinical criteria to include the two new indications for active psoriatic arthritis and active ankylosing spondylitis. Added Otezla to the criteria for medications that cannot be used in combination with Cosentyx for plaque psoriasis and psoriatic arthritis. Updated reference.
3/2017	Annual review with no changes to criteria.
3/2018	Annual review with no changes to criteria. Updated reference.
2/2019	Annual review with no changes to criteria. Updated reference.
2/2020	Annual review with no changes to criteria. Updated reference.
7/2020	Updated background and criteria to include new indication for active non-radiographic axial spondyloarthritis. Changed reauthorization duration to 12 months. Updated reference.
7/2021	Annual review. Updated background to include expanded indication for moderate to severe plaque psoriasis to pediatric patients 6 years and older. Updated reference.
2/2022	Updated background and clinical criteria with new indication for ERA. Updated reference.
2/2023	Annual review. Updated listed examples from Humira to adalimumab and added Rinvoq. Added state mandate footnote.
7/2023	Updated not receiving in combination language to targeted immunomodulator and updated examples.
1/2024	Added coverage criteria for new indication for Hidradenitis Suppurativa (HS). Updated background and reference.
1/2025	Annual review with no changes to clinical criteria. Updated examples with no change to clinical intent. Updated reference.
1/2026	Annual review. Updated not used in combination verbiage and examples with no change to clinical intent. Updated reference.