AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Cosentyx	Page:	1 of 7
Effective Date:	7/31/2026	Last Review Date:	6/15/2026
Applies to:	☒New Jersey		

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Cosentyx under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-approved Indications

- Moderate to severe plaque psoriasis (PsO) in patients 6 years of age and older who are candidates for systemic therapy or phototherapy (Reference the Biological Response Modifiers (BRMs) in the Treatment of Plaque Psoriasis NJ Protocol)
- Active psoriatic arthritis (PsA) in patients 2 years of age and older
- Adults with active ankylosing spondylitis (AS)
- Adults with active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation
- Active enthesitis-related arthritis (ERA) in patients 4 years of age and older
- Adults and pediatric patients 12 years of age and older with moderate to severe hidradenitis suppurativa (HS)

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Cosentyx

Policy/Guideline:

Documentation

Submission of the following information is necessary to initiate the prior authorization review:

Psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), enthesitis-related arthritis (ERA), and hidradenitis suppurativa

Initial requests

Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, documentation of clinical reason to avoid therapy.

Continuation requests
Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialties

This medication must be prescribed by or in consultation with ONE of the following:
- Psoriatic arthritis and hidradenitis suppurativa: rheumatologist or dermatologist
- Ankylosing spondylitis, non-radiographic axial spondyloarthritis, and enthesis-related arthritis: rheumatologist

Coverage Criteria

Psoriatic arthritis (PsA)
Authorization of 12 months may be granted for members 2 years of age or older who have previously received a biologic or targeted synthetic drug indicated for active psoriatic arthritis.

Authorization of 12 months may be granted for members 2 years of age or older for treatment of active psoriatic arthritis when EITHER of the following criteria is met:
- Member has mild to moderate disease and meets one of the following criteria:
  - Member has had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration.
  - Member has an intolerance or contraindication to methotrexate or leflunomide (see Appendix), or another conventional synthetic drug (e.g., sulfasalazine).
  - Member has enthesitis or predominantly axial disease.
- Member has severe disease.

Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)
Authorization of 12 months may be granted for adult members who have previously received a biologic or targeted synthetic drug indicated for active ankylosing spondylitis or active non-radiographic axial spondyloarthritis.
Authorization of 12 months may be granted for adult members for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis when ANY of the following criteria is met:
- Member has had an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs).
- Member has an intolerance or contraindication to two or more NSAIDs.

Enthesitis-related arthritis (ERA)
Authorization of 12 months may be granted for members 4 years of age or older who have previously received a biologic for treatment of active enthesitis-related arthritis.
Authorization of 12 months may be granted for members 4 years of age or older for treatment of active enthesitis-related arthritis when BOTH of the following criteria are met:

- Member has active disease demonstrated by at least three active joints involved and at least one site of active enthesitis at baseline or documented by history.
- Member meets EITHER of the following:
  - Member has had an inadequate response to nonsteroidal anti-inflammatory drugs (NSAIDs), sulfasalazine, or methotrexate.
  - Member has an intolerance or contraindication to NSAIDs, sulfasalazine (e.g., porphyria, intestinal or urinary obstruction), and methotrexate (see Appendix).

Hidradenitis suppurativa
Authorization of 12 months may be granted for members 12 years of age or older who have previously received a biologic indicated for treatment of moderate to severe hidradenitis suppurativa.

Authorization of 12 months may be granted for members 12 years of age or older for treatment of moderate to severe hidradenitis suppurativa when EITHER of the following is met:
- Member has had an inadequate response to an oral antibiotic used for the treatment of hidradenitis suppurativa for at least 8 weeks (e.g., clindamycin, metronidazole, moxifloxacin, rifampin, tetracyclines).
- Member has an intolerance or contraindication to oral antibiotics used for the treatment of hidradenitis suppurativa.

Continuation of Therapy

Psoriatic arthritis (PsA)
Authorization of 12 months may be granted for all members 2 years of age or older (including new members) who are using the requested medication for psoriatic arthritis and who achieve or maintain a 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)

Ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA)
Authorization of 12 months may be granted for all adult members (including new members) who are using the requested medication for ankylosing spondylitis or non-radiographic axial spondyloarthritis and who achieve or maintain a 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:

- Functional status
- Total spinal pain
- Inflammation (e.g., morning stiffness)
- Swollen joints
- Tender joints
- C-reactive protein (CRP)

Enthesitis-related arthritis (ERA)

Authorization of 12 months may be granted for all members 4 years of age or older (including new members) who are using the requested medication for active enthesitis-related arthritis and who achieve or maintain a 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 flares
- Number of joints with active arthritis (e.g., swelling, pain)
- Number of joints with limited movement
- Dactylitis
- Enthesitis

Hidradenitis suppurativa

Authorization of 12 months may be granted for all members 12 years of age or older (including new members) who are using the requested medication for moderate to severe hidradenitis suppurativa and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition when ANY of the following is met:

- Reduction in abscess and inflammatory nodule count from baseline
- Reduced formation of new sinus tracts and scarring
- Decrease in frequency of inflammatory lesions from baseline
- Reduction in pain from baseline
- Reduction in suppuration from baseline
- Improvement in frequency of relapses from baseline
- Improvement in quality of life from baseline
- Improvement on a disease severity assessment tool from baseline

Other

For all indications: Member has been evaluated for tuberculosis (TB) infection prior to initiation of treatment with a biologic or targeted synthetic drug associated with an increased risk of TB.

For all indications: Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Dosage And Administration

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Appendix

Examples of Clinical Reasons to Avoid Pharmacologic Treatment with Methotrexate, Cyclosporine, Acitretin, or Leflunomide

- Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease
- Drug interaction
- Risk of treatment-related toxicity
- Pregnancy or currently planning pregnancy
- Breastfeeding
- Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension)
- Hypersensitivity
- History of intolerance or adverse event

Approval Duration and Quantity Restrictions:

Approval:
Initial and renewal approval: 12 months

Quantity Level Limit:

- Cosentyx (secukinumab) 75 mg/0.5 mL prefilled syringe:
  - 1 syringe per 28 days
  - Exception limit: 5 syringes per 28 days
- Cosentyx (secukinumab) 150 mg/mL prefilled syringe/Sensoready pen:
  - 1 syringe/pen per 28 days
  - Exception limit: 5 syringes/pens per 28 days
- Cosentyx (secukinumab) 300 mg/2 mL prefilled syringe/UnoReady pen:
  - 1 syringe/pen per 28 days
  - Loading dose (exception limit): 5 pens/syringes per 28 days
  - Maintenance dose (HS inadequate response; exception limit): 2 pens/syringes per 28 days
- Cosentyx (secukinumab) 300 mg dose carton containing (2) 150 mg/mL prefilled syringes or (2) 150 mg/mL Sensoready pens:
  - 1 dose carton per 28 days
  - Loading dose (exception limit): 5 dose cartons per 28 days

  - Maintenance dose (HS inadequate response; exception limit): 2 dose cartons per 28 days
- Cosentyx (secukinumab) 125 mg/5 mL single-dose vial:
  - 15 mL (3 vials) per 28 days
  - Loading dose (exception limit):
    - ≤ 100 kg: 25 mL (5 vials) per 28 days
    - > 100 kg: 50 mL (10 vials) per 28 days

References:

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