Cosentyx® (secukinumab)

Service Request Form and Prescriptions
FAX: 1-844-666-1366; *PHONE: 1-844-267-3689*
Please complete all fields to prevent any delays.
Please include copies of both sides of primary and secondary insurance card(s).

Please FAX completed form to:
Fast Access Specialty Therapeutics at:
1-844-504-3278 or (p) 877-327-8881

TO BE COMPLETED BY PATIENT

PATIENT INFORMATION

Patient's Last Name | First | Middle

Birth Date | Sex: ☐ M ☐ F

Street Address

City | State | Zip Code

Home Phone | Cell Phone

E-mail

Contact me by: ☐ Cell Phone ☐ Home Phone ☐ E-mail ☐ Text
Best time to call: ☐ Morning ☐ Afternoon ☐ Evening
Preferred Language: ☐ English ☐ Spanish
OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO

PARTICIPATION IN CO-PAY ASSISTANCE PROGRAM

☐ I have read and agree to the Terms and Conditions for participation in the COSENTYX® Co-pay Assistance Program on page 3.

INSURANCE INFORMATION

Primary Insurance Name

Beneficiary/Cardholder Name

Primary Insurance ID # | Group #

Primary Insurance Phone

Prescription Insurance Name

Prescription Insurance ID # | Phone

Group # | BIN # | PCN #

☐ I have secondary insurance.

PATIENT AUTHORIZATION

I have read and agree to the Patient Authorization on pages 2 & 3.

Patient/Legal Guardian Signature | Date

TO BE COMPLETED BY PRESCRIBER

PHYSICIAN INFORMATION

First Name | Last Name

Office Contact Number | Contact Name

Site/Institution Name

Office Fax Number | Tax ID #

Office E-mail | NPI #

Address

City | State | Zip Code

SUPPORT REQUESTED FOR THIS PATIENT

Physician: Please indicate support level requested by checking ONE of the following 3 boxes:

☐ **FULL Program Support** requested (eg, benefits investigation, support for prior authorizations/appeals, Patient Services Liaison, co-pay assistance)

☐ CO-PAY ASSISTANCE ONLY

☐ BENEFITS INVESTIGATION ONLY

PLEASE NOTE: IF NONE OF THE 3 BOXES ABOVE IS CHECKED, YOU WILL BE DEEMED TO HAVE SELECTED FULL PROGRAM SUPPORT.

☐ I also request **supplemental home injection training** for this patient.

CLINICAL INFORMATION

TREATMENT HISTORY:

☐ To my knowledge, the patient has not previously been treated with a biologic for the diagnosed condition.

If patient has been treated with a biologic, please provide information below.

Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, or other biologic treatment? ☐ NO ☐ YES _____

Does this patient have documented failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, or other biologic treatment? ☐ NO ☐ YES _____

If YES, please indicate which drug(s) and date(s) of usage.

Enbrel® From: _____ To: _____ Humira® From: _____ To: _____
Remicade® From: _____ To: _____ Stelara® From: _____ To: _____
Other From: _____ To: _____ Other From: _____ To: _____

COSENTYX PRESCRIPTION INFORMATION

New York prescribers, please submit prescription on an original NY State prescription blank. The physician is to comply with their state-specific form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Indicate ICD-10 Code(s):

INITIATE PROGRAM FREE MEDICATION PRESCRIPTION (optional, for use by Program Specialty Pharmacy only)

Initiate Program (no cost to patient): Commercially insured patients who are experiencing an insurance coverage delay are eligible for free medication while awaiting coverage. Eligibility requirements and limitations apply. **Patients receiving benefits under Medicare, Medicaid, or any other federal or state program (eg, Tricare) are not eligible for this offer.** Participation is not a guarantee of availability of insurance coverage or alternative financial assistance programs. Offer is not contingent upon purchase requirements of any kind. Enrollment expires 12/31/16.

Initial Weekly Dosing (where appropriate) – Weeks 0, 1, 2, 3, and 4, then once every 4 weeks.
☐ Inject 300-mg dose subcutaneously once weekly for 5 weeks. Each 300-mg dose is given as 2 injections of 150 mg.
☐ Inject 150-mg dose subcutaneously once weekly for 5 weeks.
☐ Sensoready® Pen ☐ Prefilled Syringe

Monthly Dosing – Once every 4 weeks.
☐ Inject 300-mg dose subcutaneously every 4 weeks. Each 300-mg dose is given as 2 injections of 150 mg.
☐ Inject 150-mg dose subcutaneously every 4 weeks.
☐ Sensoready® Pen ☐ Prefilled Syringe Quantity: ☐ 1 Month # of Refills: _____

NETWORK PHARMACY PRESCRIPTION (required)

Preferred Specialty Pharmacy: Fast Access Specialty Therapeutics

Initial Weekly Dosing (where appropriate) – Weeks 0, 1, 2, 3, and 4, then once every 4 weeks.
☐ Inject 300-mg dose subcutaneously once weekly for 5 weeks. Each 300-mg dose is given as 2 injections of 150 mg.
☐ Inject 150-mg dose subcutaneously once weekly for 5 weeks.
☐ Sensoready® Pen ☐ Prefilled Syringe

Monthly Dosing – Once every 4 weeks.
☐ Inject 300-mg dose subcutaneously every 4 weeks. Each 300-mg dose is given as 2 injections of 150 mg.
☐ Inject 150-mg dose subcutaneously every 4 weeks.
☐ Sensoready® Pen ☐ Prefilled Syringe Quantity: ☐ 1 Month # of Refills: _____

SHIPPING PREFERENCES

First Dose: ☐ Physician Address ☐ Patient Address
Follow-Up Doses: ☐ Physician Address ☐ Patient Address

Co-pay Information: FOR PHARMACY USE ONLY
BIN: _____ Member ID: _____
PCN: _____ Rx Group #: _____

Special Requests:

PHYSICIAN CERTIFICATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.

Physician Signature (No Stamp Allowed) | Date

PHYSICIAN CERTIFICATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I certify that I am the physician who has prescribed COSENTYX to the previously identified patient and that I provided the patient with a description of the COSENTYX Connect Personal Support Program. I authorize the COSENTYX Connect Personal Support Program to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

Physician Signature (No Stamp Allowed) | Date