

PRIOR AUTHORIZATION PROGRAM FORM Cosentyx ® (Secukinumab)

Instructions:

Date Received:

- 1. Section 1 to be completed by Plan Member / Patient
- 2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
- 3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z-5M4

Section 1: To be completed by Patient																	
Member's Name: (Last , First) Card ID												1 1					
Welliber's Name. (Last, First)	Number:																
Patient's Name: (Last, First)	Patient's D	Date of Birth (dd/mm/yy) R						Relationship to Member (please circle) PATIENT									
	Empl					Employ	yee Spouse Dependent CODE										
Results of this request to be communicated to:																	
☐ Pharmacy ☐ Patient / Legal Guardian Named Below							☐ email:										
I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.																	
Patient / Legal Guardian Name:								Telephone Number:									
Signature of Patient/ Legal Guardian:							Date (dd/mm/yy):										
Section 2: To be completed by Physician																	
								nstructions:									
Cosentyx DIN:02438070																	
Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.																	
Please indicate if the patient meets the following qualifying criteria for drug coverage:																	
☐ Cosentyx is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy															ару		
Physician Name: (Last, First)							License Number:										
Address: (Street, City, Province, Postal Code)								Telephone Number : () -									
								Fax Number: () -									
Signature of Physician:								Date (dd/mm/yy)									
Section 3: To be completed by Pharmacist																	
Pharmacy Name:									Provider	Num	ber:						
Pharmacy Address: (Street, City, Province, Postal Code)									Telepho	ne Nu	ımber :	()	_				
									Fax Number: () -								
Signature of Pharmacist:									Fax Nun	iber:		()	-				
Pharmacist's Name: (Print Last, First)																	
									1								
Internal Office Use Only:																	

Date Approved & By: