

**POLICY:** Inflammatory Conditions – Cosentyx Intravenous Utilization Management Medical Policy

- Cosentyx® (secukinumab intravenous infusion – Novartis)

**EFFECTIVE DATE:** 3/15/2024

**LAST REVIEW DATE:** 09/16/2024

**COVERAGE CRITERIA FOR:** All Aspirus Medicare Plans

---

### OVERVIEW

Cosentyx intravenous, an interleukin (IL)-17A antagonist, is indicated in the following conditions:<sup>1</sup>

- **Psoriatic arthritis**, in adults with active disease.
- **Ankylosing spondylitis**, in adults with active disease.
- **Non-radiographic axial spondyloarthritis**, in adults with active disease and objective signs of inflammation.

In the pivotal trial for non-radiographic axial spondyloarthritis, patients were required to have objective signs of inflammation, indicated by elevated C-reactive protein and/or sacroiliitis on magnetic resonance imaging.

### Dosing Information

For approved uses, Cosentyx intravenous may be given with or without a single 6 mg/kg loading dose. The maintenance dose is 1.75 mg/kg given intravenously once every 4 weeks.

### Guidelines

The intravenous formulation of Cosentyx has not been addressed in any guidelines. However, IL-17 blockers, including the subcutaneous formulation of Cosentyx, are mentioned in guidelines for treatment of inflammatory conditions.

- **Ankylosing Spondylitis and Non-Radiographic Axial Spondyloarthritis:** Guidelines for ankylosing spondylitis and non-radiographic axial spondyloarthritis are published by the ACR/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network (2019).<sup>2</sup> Following primary nonresponse to a tumor necrosis factor inhibitor (TNFi), either Cosentyx or Taltz® (ixekizumab injection) is recommended; however, if the patient is a secondary nonresponder, a second TNFi is recommended over switching out of the class. In patients with a contraindication to a TNFi, use of an IL-17 blocker is recommended over traditional oral agents such as methotrexate or sulfasalazine.

- **Psoriatic Arthritis:** Guidelines from the American College of Rheumatology (ACR)/National Psoriasis Foundation (2018) generally recommend TNFis as the first-line treatment strategy over other biologics (e.g., IL-17 blockers) with differing mechanisms of action.<sup>3</sup>

#### **POLICY STATEMENT**

Prior Authorization is recommended for medical benefit coverage of Cosentyx intravenous. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indications. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days. Because of the specialized skills required for evaluation and diagnosis of patients treated with Cosentyx intravenous as well as the monitoring required for adverse events and long-term efficacy, initial approval requires Cosentyx intravenous to be prescribed by or in consultation with a physician who specializes in the condition being treated.

**Automation:** None.

#### **RECOMMENDED AUTHORIZATION CRITERIA**

Coverage of Cosentyx intravenous is recommended in those who meet one of the following criteria:

#### **FDA-Approved Indications**

- 
- 1. Ankylosing Spondylitis.** Approve for the duration noted if the patient meets ONE of the following (A or B):
    - A) Initial Therapy.** Approve for 6 months if the patient meets BOTH of the following (i and ii):
      - i.** Patient is  $\geq 18$  years of age; AND
      - ii.** The medication is prescribed by or in consultation with a rheumatologist.
    - B) Patient is Currently Receiving Cosentyx Intravenous or Subcutaneous.** Approve for 1 year if the patient meets BOTH of the following (i and ii):
      - i.** Patient has been established on Cosentyx intravenous or subcutaneous for at least 6 months; AND  
Note: A patient who has received  $< 6$  months of therapy or who is restarting therapy with Cosentyx intravenous or subcutaneous is reviewed under criterion A (Initial Therapy).
      - ii.** Patient meets at least ONE of the following (a or b):

- a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Cosentyx intravenous or subcutaneous); OR  
Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondyloarthropathies (HAQ-S), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate).
- b) Compared with baseline (prior to initiating Cosentyx intravenous or subcutaneous), patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living.

**Dosing.** Approve ONE of the following dosing regimens (A or B):

- A) A single 6 mg/kg intravenous loading dose followed by 1.75 mg/kg (up to a maximum of 300 mg per dose) given once every 4 weeks thereafter, up to a maximum of 300 mg per dose; OR
- B) 1.75 mg/kg (up to a maximum of 300 mg per dose) given intravenously once every 4 weeks.

---

**2. Non-Radiographic Axial Spondyloarthritis.** Approve for the duration noted if the patient meets ONE of the following (A or B):

- A) Initial Therapy. Approve for 6 months if the patient meets ALL of the following (i, ii, and iii):
  - i. Patient is  $\geq 18$  years of age; AND
  - ii. Patient has objective signs of inflammation, defined as at least ONE of the following (a or b):
    - a) C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory; OR
    - b) Sacroiliitis reported on magnetic resonance imaging; AND
  - iii. The medication is prescribed by or in consultation with a rheumatologist.
- B) Patient is Currently Receiving Cosentyx Intravenous or Subcutaneous. Approve for 1 year if the patient meets BOTH of the following (i and ii):
  - i. Patient has been established on Cosentyx intravenous or subcutaneous for at least 6 months; AND  
Note: A patient who has received < 6 months of therapy or who is restarting therapy with Cosentyx intravenous or subcutaneous is reviewed under criterion A (Initial Therapy).

- ii. Patient meets at least ONE of the following (a or b):
  - a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Cosentyx intravenous or subcutaneous); OR  
Note: Examples of objective measures include Ankylosing Spondylitis Disease Activity Score (ASDAS), Ankylosing Spondylitis Quality of Life Scale (ASQoL), Bath Ankylosing Spondylitis Disease Activity Index (BASDAI), Bath Ankylosing Spondylitis Functional Index (BASFI), Bath Ankylosing Spondylitis Global Score (BAS-G), Bath Ankylosing Spondylitis Metrology Index (BASMI), Dougados Functional Index (DFI), Health Assessment Questionnaire for the Spondyloarthropathies (HAQ-S), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate).
  - b) Compared with baseline (prior to initiating Cosentyx intravenous or subcutaneous), patient experienced an improvement in at least one symptom, such as decreased pain or stiffness, or improvement in function or activities of daily living.

**Dosing.** Approve ONE of the following dosing regimens (A or B):

- A) A single 6 mg/kg intravenous loading dose followed by 1.75 mg/kg (up to a maximum of 300 mg per dose) given once every 4 weeks thereafter, up to a maximum of 300 mg per dose; OR
- B) 1.75 mg/kg (up to a maximum of 300 mg per dose) given intravenously once every 4 weeks.

---

**3. Psoriatic Arthritis.** Approve for the duration noted if the patient meets ONE of the following (A or B):

- A) Initial Therapy. Approve for 6 months if the patient meets BOTH of the following (i and ii):
  - i. Patient is  $\geq 18$  years of age; AND
  - ii. The medication is prescribed by or in consultation with a rheumatologist or a dermatologist.
- B) Patient is Currently Receiving Cosentyx Intravenous or Subcutaneous. Approve for 1 year if the patient meets BOTH of the following (i and ii):
  - i. Patient has been established on Cosentyx intravenous or subcutaneous for at least 6 months; AND  
Note: A patient who has received < 6 months of therapy with Cosentyx intravenous or subcutaneous or who is restarting therapy is reviewed under criterion A (Initial Therapy).
  - ii. Patient meets at least ONE of the following (a or b):

- a) When assessed by at least one objective measure, patient experienced a beneficial clinical response from baseline (prior to initiating Cosentyx intravenous or subcutaneous); OR

Note: Examples of standardized measures of disease activity include Disease Activity Index for Psoriatic Arthritis (DAPSA), Composite Psoriatic Disease Activity Index (CPDAI), Psoriatic Arthritis Disease Activity Score (PsA DAS), Grace Index, Leeds Enthesitis Score (LEI), Spondyloarthritis Consortium of Canada (SPARCC) enthesitis score, Leeds Dactylitis Instrument Score, Minimal Disease Activity (MDA), Psoriatic Arthritis Impact of Disease (PsAID-12), and/or serum markers (e.g., C-reactive protein, erythrocyte sedimentation rate).

- b) Compared with baseline (prior to initiating Cosentyx intravenous or subcutaneous), patient experienced an improvement in at least one symptom, such as less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths.

**Dosing.** Approve ONE of the following dosing regimens (A or B):

- A)** A single 6 mg/kg intravenous loading dose followed by 1.75 mg/kg (up to a maximum of 300 mg per dose) given once every 4 weeks thereafter, up to a maximum of 300 mg per dose; OR
- B)** 1.75 mg/kg (up to a maximum of 300 mg per dose) given intravenously once every 4 weeks.

---

#### **CONDITIONS NOT RECOMMENDED FOR APPROVAL**

Coverage of Cosentyx intravenous is not recommended in the following situations:

**1. Concurrent Use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug.**

This medication should not be administered in combination with another biologic or with a targeted synthetic oral small molecule drug used for an inflammatory condition (see [Appendix](#) for examples). Combination therapy is generally not recommended due to a potentially higher rate of adverse events and lack of controlled clinical data supporting additive efficacy.

Note: This does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication.

- 2. Crohn's Disease.** Exacerbations of Crohn's disease, in some cases serious, occurred in clinical trials in patients treated with Cosentyx.<sup>1</sup> In a Phase II published study in patients with Crohn's disease (n = 59), an intravenous formulation of Cosentyx did not reduce the Crohn's disease activity index by  $\geq 50$  points compared with placebo and the study was terminated prematurely.<sup>4</sup>

- 3. Enthesitis-Related Arthritis.** Cosentyx subcutaneous is indicated and has approved dosing regimens for treatment of enthesitis-related arthritis.<sup>1</sup>
- 4. Plaque Psoriasis.** Cosentyx subcutaneous is indicated and has approved dosing regimens for treatment of plaque psoriasis.<sup>1</sup>
- 5. Rheumatoid Arthritis.** In a published, double-dummy Phase III study, Cosentyx was less effective than current treatments in patients with rheumatoid arthritis who were previously treated with a tumor necrosis factor inhibitor (TNFi).<sup>5</sup> Patients were randomized to one of four treatment groups: 1) induction with an intravenous formulation of Cosentyx (10 mg/kg) followed by Cosentyx 150 mg subcutaneously given once every 4 weeks (Q4W) [n = 137]; 2) secukinumab intravenous induction (10 mg/kg) followed by Cosentyx 75 mg subcutaneously Q4W (n = 138). At Week 24, ACR 20 response was significantly better with Cosentyx 150 mg subcutaneous (31%) and Orencia intravenous (43%) vs. placebo (18%). ACR 20 response with Cosentyx 75 mg was 28%, which was not significantly better than the placebo group. ACR 50/70 responses were 17%/10% with Cosentyx 150 mg and 12%/5% with Cosentyx 75 mg which were not significantly different from that of placebo (9%/5%). The group treated with Orencia intravenous had significantly improved ACR 50/70 responses at Week 24 (28%/12%). Using as observed data, ACR 20/50/70 responses at Week 52 were 63%/46%/19% with Cosentyx 150 mg, 57%/26%/7% with Cosentyx 75 mg, and 75%/52%/23% with Orencia intravenous. There is a published Phase II dose-ranging study (n = 237) evaluating Cosentyx in rheumatoid arthritis.<sup>6-8</sup> The ACR 20 response at Week 16 (using last observation carried forward analysis) was 34%, 46.9%, 46.5%, 53.7% for the 25, 75, 150, and 300 mg doses vs. 36% for placebo; however, this did not achieve statistical significance. After Week 16, patients who responded to Cosentyx had sustained response through Week 52, with patients on the 150 mg dose having the greatest improvement over time (55% and 40% of patients with ACR 50 and ACR 70 responses, respectively, at Week 52). In another Phase II study, Cosentyx did not achieve higher ACR 20 response rates at Week 12 vs. placebo.<sup>9</sup> There was an open-label treatment period where ACR responses were generally maintained through Week 52. Some patients were treated with an intravenous formulation of secukinumab and generally responded similarly to those treated with Cosentyx subcutaneous. In another Phase II study, an intravenous formulation of secukinumab demonstrated limited efficacy in biologic-naïve patients with rheumatoid arthritis associated with the HLA-DRB1 allele.<sup>10</sup>
- 6.** Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

**REFERENCES**

1. Cosentyx® [prescribing information]. East Hanover, NJ: Novartis; October 2023.
2. Ward MM, Deodhar A, Gensler LS, et al. 2019 update of the American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2019;(10):1599-1613.
3. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. *Arthritis Rheumatol.* 2019;71(1):5-32.
4. Hueber W, Sands BE, Lewitzky S, et al. Secukinumab, a human anti-IL-17A monoclonal antibody, for moderate to severe Crohn's disease: unexpected results of a randomised, double-blind placebo-controlled trial. *Gut.* 2012;61(12):1693-1700.
5. Blanco FJ, Möricke R, Dokoupilova E, et al. Secukinumab in active rheumatoid arthritis: a Phase III randomized, double-blind, active comparator- and placebo-controlled study. *Arthritis Rheumatol.* 2017;69(6):1144-1153.
6. Genovese MC, Durez P, Richards HB, et al. One-year efficacy and safety results of secukinumab in patients with rheumatoid arthritis: phase II, dose-finding, double-blind, randomized, placebo-controlled study. *J Rheumatol.* 2014;41(3):414-421.
7. Genovese MC, Durez P, Richards HB, et al. Efficacy and safety of secukinumab in patients with rheumatoid arthritis: a phase II, dose-finding, double-blind, randomised, placebo controlled study. *Ann Rheum Dis.* 2013;72(6):863-869.
8. Strand V, Kosinski M, Gnanasakthy A, et al. Secukinumab treatment in rheumatoid arthritis is associated with incremental benefit in the clinical outcomes and HRQoL improvements that exceed minimally important thresholds. *Health Qual Life Outcomes.* 2014;12:31.
9. Tlustochowicz W, Rahman P, Serio B, et al. Efficacy and safety of subcutaneous and intravenous loading dose regimens of secukinumab in patients with active rheumatoid arthritis: results from a randomized Phase II study. *J Rheumatol.* 2016;43(3):495-503.
10. Burmester GR, Durez P, Shestakova G, et al. Association of HLA-DRB1 alleles with clinical responses to the anti-interleukin-17A monoclonal antibody secukinumab in active rheumatoid arthritis. *Rheumatology (Oxford).* 2016;55(1):49-55.

**HISTORY**

<b>Type of Revision</b>	<b>Summary of Changes</b>	<b>Review Date</b>
New Policy	--	11/01/2023
Selected Revision	<b>Conditions Not Recommended for Approval:</b> Concurrent use with a Biologic or with a Targeted Synthetic Oral Small Molecule	09/11/2024

	Drug was changed to as listed (previously oral small molecule drug was listed as Disease-Modifying Antirheumatic Drug).	
Aspirus P&T Review	Policy reviewed and approved by Aspirus P&T committee. Annual review process	09/16/2024



**APPENDIX**

	<b>Mechanism of Action</b>	<b>Examples of Inflammatory Indications*</b>
<b>Biologics</b>		
<b>Adalimumab SC Products</b> (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
<b>Cimzia®</b> (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
<b>Etanercept SC Products</b> (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA
<b>Zymfentra®</b> (infliximab-dyyb SC injection)	Inhibition of TNF	CD, UC
<b>Infliximab IV Products</b> (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
<b>Simponi®, Simponi® Aria™</b> (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
<b>Actemra®</b> (tocilizumab IV infusion, tocilizumab SC injection)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
<b>Kezara®</b> (sarilumab SC injection)	Inhibition of IL-6	RA, PMR
<b>Orencia®</b> (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PSA, RA
		IV formulation: JIA, PsA, RA
<b>Rituximab IV Products</b> (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
<b>Kineret®</b> (anakinra SC injection)	Inhibition of IL-1	JIA <sup>^</sup> , RA
<b>Stelara®</b> (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
<b>Siliq™</b> (brodalumab SC injection)	Inhibition of IL-17RA	PsO
<b>Bimzelx®</b> (bimekizumab-bkzx SC injection)	Inhibition of IL-17A and IL-17F	PsO
<b>Cosentyx®</b> (secukinumab SC injection, secukinumab IV infusion)	Inhibition of IL-17A	SC formulation: AS, ERA, nr-axSpA, PsO, PsA
		IV formulation: AS, nr-axSpA, PsA
<b>Taltz®</b> (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
<b>Ilumya™</b> (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
<b>Skyrizi®</b> (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PSA, PsO
		IV formulation: CD
<b>Tremfya™</b> (guselkumab SC injection)	Inhibition of IL-23	PsO
<b>Entyvio™</b> (vedolizumab IV infusion, vedolizumab SC injection)	Integrin receptor antagonist	SC formulation: UC
		IV formulation: CD, UC
<b>Oral Therapies/Targeted Synthetic DMARDs</b>		
<b>Otezla®</b> (apremilast tablets)	Inhibition of PDE4	PsO, PsA
<b>Cibinqo™</b> (abrocitinib tablets)	Inhibition of JAK pathways	AD
<b>Olumiant®</b> (baricitinib tablets)	Inhibition of JAK pathways	RA
<b>Rinvoq®</b> (upadacitinib extended-release tablets)	Inhibition of JAK pathways	AD, AS, nr-axSpA, RA, PsA, UC
<b>Sotyktu™</b> (deucravacitinib tablets)	Inhibition of TYK2	PsO
<b>Xeljanz®</b> (tofacitinib tablets)	Inhibition of JAK pathways	RA, PJIA, PsA, UC
<b>Xeljanz® XR</b> (tofacitinib extended-release tablets)	Inhibition of JAK pathways	RA, PsA, UC

\* Not an all-inclusive list of indications (e.g., oncology indications and rare inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; PMR – Polymyalgia rheumatic; <sup>^</sup> Off-label use of Kineret in JIA supported in guidelines; ERA – Entesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis; TYK2 – Tyrosine kinase 2.