SENTARA COMMUNITY PLAN
(MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-305-2331**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

Drug Requested: Spevigo® (spesolimab-sbzo) **(J1747) (Medical)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- **Spevigo 450 mg/7.5 mL (60 mg/mL) two-pack single-dose vial (SDV): 00597-0035-xx**
- **Spevigo 450 mg/7.5 mL solution in an SDV: 2 vials one time only**

B. Max Units (per dose and over time) [HCPCS Unit]:

- **900 mg (2 vials) on day 1**

***NOTE: Spevigo has not been studied in patients with plaque psoriasis without generalized pustular psoriasis and will not be permitted for treatment of this condition.**

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Treatment of generalized pustular psoriasis flares**

900mg IV once, may be given again if symptoms persist after one week
600mg subQ once, then 300mg subQ every 4 weeks

- ❑ Member is at least 12 years of age or older weighing 40 or more kg
- ❑ Medication is prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis
- ❑ Member has a known documented history of GPP (either relapsing [greater than 1 episode] or persistent [greater than 3 months]
- ❑ Member is presenting with primary, sterile, macroscopically visible pustule on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques)
- ❑ Member has at least *one* of the following documented:
  - ❑ IL36RN, CARD14, or AP1S3 gene mutation
  - ❑ Skin biopsy confirming presence of Kogoj's spongiform pustules
  - ❑ Systemic symptoms or laboratory abnormalities commonly associated with GPP flare (e.g., fever, asthenia, myalgia, elevated C-reactive protein [CRP], leukocytosis, neutrophilia [above ULN]
  - ❑ GPP flare of moderate-to-severe intensity (e.g., at least 5% body surface area is covered with erythema and the presence of pustules; Generalized Pustular Psoriasis Physician Global Assessment [GPPPGA] total score of greater or equal to 3)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Diagnosis: Treatment of generalized pustular psoriasis <u>without</u> flares**

Loading dose: 600 subQ (four 150mg injections), followed by 300mg subQ (two 150mg injections) 4 weeks later and every 4 weeks thereafter

- ❑ Member is at least 12 years of age or older weighing 40 or more kg
- ❑ Medication is prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis
- ❑ Member has a known documented history of GPP (either relapsing [greater than 1 episode] or persistent [greater than 3 months])

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Medication being provided by: **Please check applicable box below.**

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____
  OR
- ❑ **Specialty Pharmacy – Proprium Rx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: 11/18/2022 **REVISED/UPDATED/REFORMATTED:** 11/29/2022; 6/26/2023; ~~6/112024,~~ **8/27/2024**