SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. 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® SQ (spesolimab-sbzo) **(Pharmacy)**

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:** _____

***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.**

The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has NOT been established and will NOT be permitted.

Recommended Dosing:

- Maintenance therapy (following IV treatment of active flare): SUBQ: 300 mg (two 150 mg injections) starting 4 weeks after last IV dose, then every 4 weeks thereafter
- Maintenance therapy (initiation of therapy in patients without an active flare): SUBQ: 600 mg (four 150 mg injections) as a loading dose at week 0, followed by 300 mg (two 150 mg injections) at week 4, then every 4 weeks thereafter

Quantity Limit: 2 syringes per 28 days

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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 <u>without</u> flares**
<u>Authorization</u>: 12 months
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])

Medication being provided by Specialty Pharmacy - PropriumRx

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,~~ **9/22/2024**