SENTARA HEALTH PLANS

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 the information provided is not complete, correct, or legible, the authorization process 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 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 as a loading dose at week 0, followed by 300 mg at week 4, then every 4 weeks thereafter

Quantity Limit: 2 mL 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: Generalized Pustular Psoriasis (GPP) – Maintenance

Initial Authorization: 6 months

- ❑ Member is ≥ 12 years of age and weighs ≥ 40 kg
- ❑ Medication is prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis
- ❑ Member must meet **ONE** of the following **(verified by chart notes and/or pharmacy & medical paid claims)**:
  - ❑ Member has previously received treatment with Spevigo® for active flare within the past 4 weeks and provider is requesting a maintenance dose of 300 mg starting 4 weeks after last IV dose, then every 4 weeks thereafter
  - ❑ Member has **NOT** previously received treatment with Spevigo® for acute or maintenance therapy and provider is submitting prior authorization to initiate therapy for treatment of generalized pustular psoriasis without an active flare with the following dosage regimen: 600 mg as a loading dose at week 0, followed by 300 mg at week 4, then every 4 weeks thereafter
  - ❑ Member has previously received treatment with Spevigo® for maintenance therapy under the current or previous health plan and provider is requesting continuation of therapy with a maintenance dose of 300 mg every 4 weeks **(Provider please note: Use of samples to initiate therapy does NOT meet preauthorization criteria)**
- ❑ Member has a known documented history of diagnosis of GPP (e.g., presence of primary, sterile, macroscopically visible pustule on non-acral skin *NOT* restricted to psoriatic plaques) and is **NOT** currently experiencing a disease flare, **AND** meets **ALL** the following **(verified by chart notes)**:
  - ❑ Member has a known documented history of GPP (either relapsing [≥ 1 episode] or persistent [≥ 3 months])
  - ❑ Member has a GPPPGA total score of 0 or 1
  - ❑ Member has had least **TWO** GPP flares of moderate-to-severe intensity with fresh pustulation in the past (BSA ≥ 5% covered with erythema and the presence of pustules; GPPPGA total ≥ 3)
- ❑ Member meets **ONE** of the following **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member has had a 4-month trial of at least one treatment for generalized pustular psoriasis (e.g., methotrexate, acitretin, cyclosporine, or biologics) **AND** member has had a history of flaring while on treatment, with dose reduction, or discontinuation of treatment
  - ❑ Member has tried at least one treatment for generalized pustular psoriasis but was unable to tolerate a 4-month trial
- ❑ Member has received all age-appropriate vaccinations according to current immunization guidelines prior to initiating treatment

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- ❑ Member does **NOT** have any of the following conditions
  - Synovitis-acne-pustulosis-hyperostosis-osteitis (SAPHO) syndrome
  - Primary erythrodermic psoriasis vulgaris
  - Primary plaque psoriasis vulgaris without presence of pustules or with pustules that are restricted to psoriatic plaques
  - Drug-triggered Acute Generalized Exanthematous Pustulosis (AGEP)
- ❑ Member has been evaluated and screened for the presence of latent tuberculosis (TB) infection prior to initiating treatment and will receive ongoing monitoring for presence of TB during treatment
- ❑ Member does **NOT** have an active infection, including clinically important localized infections
- ❑ Member will **NOT** receive live vaccines (viral and/or bacterial) during therapy
- ❑ Member is **NOT** on concurrent treatment with an IL-inhibitor, TNF-inhibitor, biologic response modifier or other non-biologic agent (e.g., apremilast, abrocitinib, tofacitinib, baricitinib, upadacitinib, deucravacitinib)

❑ Diagnosis: Generalized Pustular Psoriasis (GPP) – Maintenance

Reauthorization: **12 months.** 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.

- ❑ Member must have a positive clinical response, defined as improvement from baseline (prior to initiating the requested drug) in at least **ONE** of the following:
  - ❑ Reduction of generalized pustular psoriasis flares
  - ❑ Improvement in Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) score

Medication being provided by a Specialty Pharmacy – Proprium Rx

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.*