Spesolimab-sbzo

Included Products: Spevigo (spesolimab-sbzo)

Nonformulary for outpatient benefit. PA required on medical benefit.

Created: 01/12/2023 *Revised:* 05/11/2023 *Reviewed:* 01/12/2023 *Updated:* 06/01/2023

All Diagnoses

Initial Criteria		If yes	If no
1.	Does the member have a diagnosis of generalized pustular psoriasis?	Continue to #2.	Do not approve.
2.	Is the request from a dermatologist?	Continue to #3.	Do not approve.
3.	Has the risk of infections been addressed by the following? a. Initial testing for latent TB and treatment, if necessary, before starting therapy. b. No current active infection at initiation of therapy. c. Risks and benefits documented in cases of chronic or recurrent infection.	Continue to #4.	Do not approve.
4.	Does the member have chronic, moderate to severe generalized pustular psoriasis at baseline with functional impairment and one or more of the following? a. At least 10% body surface area involved b. Hand, foot, face, or mucous membrane involvement	Continue to #7.	Continue to #5.
5.	Is the member under the age of 21?	Continue to #6.	Do not approve.
6.	Is it medically necessary or medically appropriate to treat the psoriasis due to contributing factors to a comorbid condition or impact on growth, learning, or development?	Continue to #7.	Do not approve based on medical necessity or appropriateness.

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7.	Has the member tried and failed or have contraindications to ALL of the following? a. High-potency topical corticosteroids, such as augmented betamethasone cream 0.05%, desoximetasone 0.25% cream, or clobetasol, and b. At least one other topical agent: calcipotriene, tazarotene, anthralin, tar, and c. PUVA or UVB Phototherapy, and d. Methotrexate, and e. At least one other second line systemic agent, such as cyclosporine or acitretin.	Continue to #8.	Do not approve.
8.	Has the member failed infliximab?	Continue to #9.	Do not approve.
9.	Has the member failed the following? a. At least one other TNF inhibitor (Enbrel or adalimumab). b. At least one IL-17/23 inhibitor (Cosentyx, Siliq, Stelara, Taltz)	Continue to #10.	Do not approve.
10.	Approve 1 dose of 900 mg.		
Renewal Criteria		**If yes**	**If no**
1.	Is this a request for a second dose 1 week after an initial dose was administered?	Continue to #2.	Do not approve.
2.	Does the member currently have a GPPGA score >2?	Continue to #3.	Do not approve.
3.	Approve x 1 additional dose of 900 mg		