Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Spevigo
(spesolimab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:

☐ Spevigo vial for intravenous
☐ Spevigo subcutaneous

ICD10:

Dose and Quantity:
Frequency of administration:

Duration of therapy:

J-code:

How much does the patient weigh?
☐ Less than 40 kilograms (kg)
☐ 40 kilograms (kg) or more

Is the requested dosing 900 mg per dose administered by intravenous (IV) infusion? ☐ Yes ☐ No

(if yes) If a second dose is administered, will the prescriber ensure that 7 days elapse between the doses? ☐ Yes ☐ No

(if yes) If this a new flare, will the prescriber ensure that at least 12 weeks have elapsed since the last dose of Spevigo?

☐ Yes
☐ No
☐ Not a new flare

Please provide clinical support for requesting this DOSE for your patient (examples could include past doses tried, past medications tried, pertinent patient history).

Besides the drug being requested, other biologics include Actemra, adalimumab (Humira and all biosimilars), Cimzia, Cosentyx, Etanercept SC Products (Enbrel, biosimilars), Entyvio, Ilumya, Infliximab IV Products (Remicade, biosimilars), Kevzara, Kineret, Orencia, Rituximab IV Products (Rituxan, biosimilars), Siliq, Simponi Aria, Simponi, Skyrizi, Stelara, Taltz, Tremfya. Which of the following best describes your patient's situation for treatment of Generalized Pustular Psoriasis?

☐ The patient is NOT taking any other biological at this time for Generalized Pustular Psoriasis, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological for Generalized Pustular Psoriasis, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological for Generalized Pustular Psoriasis, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biological for Generalized Pustular Psoriasis.
☐ Other/Unknown

Please provide the rationale for concurrent use.

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Generalized Pustular Psoriasis Flare
☐ Plaque Psoriasis
☐ other (please specify):

Clinical Information:

Is the patient experiencing a moderate-to-severe flare? ☐ Yes ☐ No

Is the patient currently receiving Spevigo SUBCUTANEOUS INJECTION?
☐ Yes, Patient is currently receiving Spevigo subcutaneous injection.
☐ No, Patient is not currently receiving Spevigo subcutaneous injection.

(if receiving) Has the patient had an increase in Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of at least 2 points? ☐ Yes ☐ No

(if receiving) Does your patient have a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) pustulation subscore of at least 2 points? ☐ Yes ☐ No

(if NOT receiving) Does your patient have new or worsening pustules? ☐ Yes ☐ No

(if NOT receiving) Does your patient have a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of at least 3 points? Note: The Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score ranges from 0 (clear skin) to 4 (severe disease). ☐ Yes ☐ No

(if NOT receiving) Does your patient have a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) pustulation subscore of at least 2 points? ☐ Yes ☐ No

(if NOT receiving) Does your patient have erythema and pustules which affect at least 5% of their body surface area? ☐ Yes ☐ No

Has the patient already received Spevigo INTRAVENOUS?
☐ Yes, patient has already received Spevigo intravenous.
☐ No, patient has NOT already received Spevigo intravenous.

(if received IV) Has the patient already received two doses of Spevigo intravenous? ☐ Yes ☐ No

(if yes) Did the patient receive both doses for treatment of the current flare? ☐ Yes ☐ No

(if yes) Has it been at least 12 weeks since the last dose of Spevigo? ☐ Yes ☐ No

Is the requested medication being prescribed by (or in consultation with) a dermatologist? ☐ Yes ☐ No

Additional Information Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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