Spevigo

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical*	❑ *Home*	❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital*	❑ *Office*	❑ *Pharmacy*

What is the ICD-10 code? _____

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Spevigo SGM 5580-A – 05/2025.

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Criteria Questions:

1. Will the requested drug be used in combination with any other biologic or targeted synthetic drug for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Rinvoq, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [TST], interferon-release assay [IGRA]) within 12 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *No further questions*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*
❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*
❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?
❒ Generalized pustular psoriasis (GPP) flare, *Continue to 7*
❒ Generalized pustular psoriasis (GPP) when not experiencing a flare, *Continue to 15*
❒ Other, please specify _____, *No further questions*

7. Is the patient 12 years of age or older?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Does the patient have a known documented history of generalized pustular psoriasis (either relapsing [greater than 1 episode] or persistent [greater than 3 months])? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation of history of generalized pustular psoriasis.
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Is the patient presenting with primary, sterile, macroscopically visible pustules (new or worsening) on an erythematous base (excluding cases where pustulation is restricted to psoriatic plaques)? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation of presentation of pustules.
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Is the generalized pustular psoriasis (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 greater or equal to 3)? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation supporting GPP flare of moderate-to-severe intensity.
❒ Yes, *No Further Questions*
❒ No, *Continue to 12*

12. Does the patient have systemic symptoms or laboratory abnormalities commonly associated with generalized pustular psoriasis (GPP) flares (e.g., fever, asthenia, myalgia, elevated C-reactive protein [CRP], leukocytosis, neutrophilia [above ULN])? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation supporting systemic symptoms or laboratory abnormalities.
❒ Yes, *No Further Questions*
❒ No, *Continue to 13*

13. Did the patient have a skin biopsy to confirm the presence of Kogoj's spongiform pustules? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation of skin biopsy.
❒ Yes, *No Further Questions*
❒ No, *Continue to 14*

14. Does the patient have a documented IL36RN, CARD14, or AP1S3 gene mutation? ***ACTION REQUIRED***: Please attach chart note(s), medical record documentation, or genetic test result(s) supporting gene mutation.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

15. Is the patient 12 years of age or older?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 18*
❒ No, *Continue to 20*

18. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 20*

❒ No, *Continue to 19*

❒ Unknown, *Continue to 20*

19. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

20. Does the patient have a known documented history of generalized pustular psoriasis (either relapsing [greater than 1 episode] or persistent [greater than 3 months])? ***ACTION REQUIRED***: Please attach chart note(s) or medical record documentation of history of generalized pustular psoriasis.
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Does the patient currently have clear to almost clear skin?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Has the patient had at least two moderate-to-severe generalized pustular psoriasis (GPP) flares (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) in the past? ***ACTION REQUIRED***: If Yes, please attach chart note(s) or medical record documentation of history of GPP flares.
❒ Yes, *Continue to 24*
❒ No, *Continue to 23*

23. Has the patient experienced flaring while on concomitant generalized pustular psoriasis (GPP) treatment (e.g., retinoids, methotrexate, cyclosporine)? ***ACTION REQUIRED***: If yes, please attach chart note(s) or medical record documentation of history of GPP flares and chart note(s), medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is a loading dose prescribed?
❒ Yes, *Continue to 25*
❒ No, *No Further Questions*

25. Does the prescribed loading dose exceed a dose of 600 mg?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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