BlueCross BlueShield Federal Employee Program

SPEVIGO
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

Spevigo

(spesolimab-sbzo)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 4 IV vials and 26 SC syringes for 12 months of therapy? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ IV vials and _____ SC syringes for 12 months of therapy

1. Does the patient have a diagnosis of generalized pustular psoriasis (GPP)? ❑Yes ❑No
2. Does the prescriber agree to monitor for hypersensitivity reactions, including drug reaction with eosinophilia and systemic symptoms (DRESS)? ❑Yes ❑No
3. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB)? ❑Yes ❑No
5. What is the patient's weight? _____ kg **OR** _____ lbs
6. Will Spevigo be used in combination with any other biologic *disease-modifying antirheumatic drugs (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No

   If YES, please specify the medication: _____

   DMARDs: Actemra, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

7. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following question:

   a. Is the patient's GPP flare of moderate to severe intensity (e.g., at least 5% of body surface area covered with erythema and the presence of pustules)? ❑Yes ❑No

   b. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No

      If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*

      If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB infection? ❑Yes ❑No

   c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to one of the following: methotrexate, cyclosporine, or an oral retinoid? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

   a. Has there been an improvement or stabilization of the patient's condition such as a reduction in the frequency or severity of flares? ❑Yes ❑No

