



AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name: Spevigo

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Effective Date: 10/21/2024

Last Review Date: 4/30/2024;
9/2024

Applies to:	<input checked="" type="checkbox"/> Illinois	<input type="checkbox"/> Florida	<input checked="" type="checkbox"/> Florida Kids
	<input type="checkbox"/> New Jersey	<input checked="" type="checkbox"/> Maryland	<input type="checkbox"/> Michigan
	<input checked="" type="checkbox"/> Pennsylvania Kids	<input type="checkbox"/> Virginia	<input checked="" type="checkbox"/> Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Spevigo under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

For the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg.

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Spevigo

Policy/Guideline:


Documentation:

Submission of the following information is necessary to initiate the prior authorization review:

- A. Generalized pustular psoriasis (GPP) flare
 - A. Chart notes or medical record documentation of history of GPP.
 - B. Chart notes or medical record documentation of clinical presentation of pustules and affected area(s).
 - C. Genetic test results, laboratory results, biopsy results, GPP severity assessment (e.g., Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) score), if applicable.
- B. Generalized pustular psoriasis (GPP) when not experiencing a flare
 - A. Initial requests:
 - 1. Chart notes or medical record documentation of history of GPP, including history of flares.
 - 2. Chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
 - B. Continuation requests: Chart notes or medical record documentation supporting positive clinical response.

Prescriber Specialty:

This medication must be prescribed by or in consultation with a dermatologist.

	
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Criteria for Initial Approval:

A. Generalized pustular psoriasis (GPP) flare

Authorization of 1 month may be granted for treatment of generalized pustular psoriasis flares in members 12 years of age or older when ALL the following criteria are met:

1. Member has a known documented history of GPP (either relapsing [greater than 1 episode] or persistent [greater than 3 months]).
2. Member is presenting with primary, sterile, macroscopically visible pustules (new or worsening) on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques).
3. Member has at least ONE of the following documented:
 - i. IL36RN, CARD14, or AP1S3 gene mutation.
 - ii. Skin biopsy confirming presence of Kogoj's spongiform pustules.
 - iii. Systemic symptoms or laboratory abnormalities commonly associated with GPP flare (e.g., fever, asthenia, myalgia, elevated C-reactive protein [CRP], leukocytosis, neutrophilia [above ULN]).
 - iv. 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 of greater or equal to 3).

B. Generalized pustular psoriasis (GPP) when not experiencing a flare

Authorization of 12 months may be granted for treatment of generalized pustular psoriasis in members 12 years of age or older when ALL the following criteria are met:

1. Member has a known documented history of GPP (either relapsing [greater than 1 episode] or persistent [greater than 3 months]).
2. Member meets either of the following:
 - i. Member has had a history of at least two moderate-to-severe 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).
 - ii. Member has a history of flaring while on concomitant treatment (e.g., retinoids, methotrexate, cyclosporine).
3. Member currently has clear to almost clear skin.

Continuation of Therapy:

A. Generalized pustular psoriasis (GPP) flare



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All members 12 years of age or older (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

B. Generalized pustular psoriasis (GPP) when NOT experiencing a flare

Authorization of 12 months may be granted for all members 12 years of age or older (including new members) who are using the requested medication for GPP when NOT experiencing a flare and who achieve or maintain a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition.

Other:

Member has had a documented negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-release assay [IGRA])* within 6 months of initiating therapy for persons who are naïve to biologic drugs or targeted synthetic drugs associated with an increased risk of TB.

* If the screening testing for TB is positive, there must be further testing to confirm there is no active disease (e.g., chest x-ray). Do not administer the requested medication to members with active TB infection. If there is latent disease, TB treatment must be started before initiation of the requested medication.

Member cannot use the requested medication concomitantly with any other biologic drug or targeted synthetic drug for the same indication.

Approval Duration and Quantity Restrictions:

Generalized pustular psoriasis (GPP) flare: 1 month

Generalized pustular psoriasis (GPP) when NOT experiencing a flare: 12 months

Quantity Level Limit: 4 vials (2 doses) per 14 days

References:

1. Spevigo [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; March 2024.
2. Bachelez H, Choon SE, Marrakchi S, et al. Trial of Spesolimab for Generalized Pustular Psoriasis. *N Engl J Med*. 2021;385(26):2431-2440.
3. Ly K, Beck KM, Smith MP, Thibodeaux Q, Bhutani T. Diagnosis and screening of patients with generalized pustular psoriasis. *Psoriasis (Auckl)*. 2019;9:37-42.
4. Fujita H, Gooderham M, Romiti R. Diagnosis of Generalized Pustular Psoriasis. *Am J Clin Dermatol*. 2022;23(Suppl 1):31-38.



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5. Choon SE, Navarini AA, Pinter A. Clinical Course and Characteristics of Generalized Pustular Psoriasis. *Am J Clin Dermatol*. 2022 Jan;23(Suppl 1):21-29.
6. Navarini AA, Burden AD, Capon F, et al. European consensus statement on phenotypes of pustular psoriasis. *J Eur Acad Dermatol Venereol*. 2017;31(11):1792-1799.
7. Zheng M, Jullien D, Eyerich K. The Prevalence and Disease Characteristics of Generalized Pustular Psoriasis. *Am J Clin Dermatol*. 2022;23(Suppl 1):5-12.
8. Morita A, Choon SE, Bachelez H, et al. Design of Effisayil™ 2: A Randomized, Double-Blind, Placebo-Controlled Study of Spesolimab in Preventing Flares in Patients with Generalized Pustular Psoriasis. *Dermatol Ther (Heidelb)*. 2023;13(1):347-359.
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