Spevigo® (spesolimab-sbzo) Medication Precertification Request

(All fields must be completed and legible for precertification review.)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Dermatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Spevigo Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drugs (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drugs (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

(Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

→ Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:
☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has been completed
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB

☐ Yes ☐ No Is the requested drug prescribed by, or in consultation, with a dermatologist?

☐ Yes ☐ No Does patient have a known documented history of generalized pustular psoriasis (either relapsing [greater than 1 episode] or persistent [greater than 3 months])?

☐ Yes ☐ No Is the presenting with primary, sterile, macroscopically visible pustules on non-acral skin excluding cases where pustulation is restricted to psoriatic plaques)?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Is the generalized pustular psoriasis (GPP) flare of moderate to severe intensity (e.g., at least 5% body surface area is covered in erythema and the presence of pustules; Generalized Pustular Psoriasis Physician Global Assessment [GPPPGA] total score greater or equal to 3)?

→ ☐ Yes ☐ No 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])?

→ ☐ Yes ☐ No Did the patient have a skin biopsy to confirm the presence of Kogoj's spongiform pustules?

→ ☐ Yes ☐ No Does the patient have a documented IL36RN, CARD14, or AP1S3 gene mutation?

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.