Field Name	Field Description
Prior Authorization Group Description	**Generalized Pustular Psoriasis (GPP) Agents**
Drugs	Spevigo (spesolimab-abzo)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Per package insert
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or geneticist
Coverage Duration	Acute Flares (IV vial): If all of the criteria are met, the request will be approved for up to 2 doses. Maintenance Treatment (SQ syringe): If all criteria are met, the initial request will be approved for 12 months. Reauthorization requests will be approved for 12 months.

Other Criteria	**<u>Initial Authorization</u>**
	• Diagnosis of generalized pustular psoriasis (GPP)
	• If request is for an acute GPP flare (IV vial), member must be experiencing an acute flare of GPP of moderate to severe intensity as defined by having all of the following:
	  o Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of 3 or greater
	  o Presence of fresh pustules (new appearance or worsening of pustules)
	  o GPPPGA pustulation sub score of 2 or greater
	  o At least 5% of body surface area covered with erythema and the presence of pustules
	• If request is for maintenance treatment of GPP (SQ syringe), member must have all of the following:
	  o History of at least two GPP flares in the past year of moderate to severe intensity
	  o GPPPGA score of 0 or 1
	  o Documented trial and failure, intolerance, or contraindication to TWO of the following: oral retinoids, methotrexate, and cyclosporine
	• Medication is prescribed at an FDA approved dose

Date: 7/2024	**<u>Reuathorization</u>** • If request is for an acute GPP flare (IV vial), member must have achieved a clinical response, defined as achieving a GPPPGA score of 0 or 1, to previous treatment but is now experiencing a new flare • If request is for maintenance treatment of GPP (SQ syringe), member must have documentation of positive clinical response to therapy (i.e. reduction in GPP flares) • Medication is prescribed at an FDA approved dose **If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.**