

SPEVIGO
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

| | | | |
|-----------------------|-------------------|---------------|--------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| Patient Address: | City, State, Zip: | | Patient Telephone: |
| Member ID Number: | | Group Number: | |

PRESCRIBER/CLINIC INFORMATION

| | | | |
|-------------------|------------------|-----------------|---------------|
| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
| Clinic Name: | | Clinic Address: | |
| City, State, Zip: | | Phone #: | Secure Fax #: |

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

| | |
|---|---------------------|
| Patient’s Diagnosis: <input type="checkbox"/> Generalized pustular psoriasis (GPP) <input type="checkbox"/> Other (ICD code, plus description): _____ | |
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |

For all requests:

- What is the patient’s weight? _____ (kg)
- Is the patient currently being treated with the requested agent?..... Yes No
- Does the patient have any FDA labeled contraindications to the requested agent?..... Yes No
 If yes, please specify contraindications: _____
- Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., dermatologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis? Yes No
- Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____
- Does the patient have active or latent tuberculosis (TB)?..... Yes No
 If yes, has the patient begun or completed therapy for latent TB prior to initiating therapy with the requested agent? Yes No
- Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

| | | | |
|---|-------|---|-------------------|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| <p>8. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Fasenra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Inflectra (infliximab-dyyb), Imuldosa (ustekinumab-srlf), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlectinib), Nemluvio (nemolizumab-ilito), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tysabri (natalizumab), Ustekinumab, Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, does the prescribing information for the requested agent limit use with another immunomodulatory agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If no, is there support for the use of combination therapy? Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required...... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | |
| For generalized pustular psoriasis (GPP) requests: | | | |
| <p>9. Do ALL of the following apply: 1) The patient has moderate-to-severe GPP, 2) the patient has a history of 2 or more flares, AND 3) the patient is NOT currently experiencing an acute flare?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | |
| For renewal requests: | | | |
| <p>8. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | | | |
| <p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p> <p>Phone: 800.285.9426 BCBSIL: 800.285.9426 BCBSMT: 888.723.7443 BCBSNM: 800.544.1378 BCBSOK: 800.991.5643 BCBSTX: 800.289.1525</p> | | <p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p> | |