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Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

March 31, 2025

SPESOLIMAB-SBZO (SPEVIGO) UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Spesolimab-sbzo (Spevigo) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective June 1, 2025,** the criteria for Spevigo will be updated to include a quantity limit. **This letter is a notification of the upcoming change in prior authorization criteria required before administering this medication in a physician's office.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente) requires prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Prior Authorization Criteria for Spevigo (changes are in bold):

DRUG NAME	COVERAGE CRITERIA

SPESOLIMAB-SBZO	Covered for patients newly starting therapy who meet all of the following criteria:
	• Diagnosis of generalized pustular psoriasis (GPP)
	• Patient is at least 12 years of age and weighs at least 40 kg
	• Prescribed by a Dermatologist
	• Patient is currently experiencing a moderate to severe GPP flare based on at least one of the following:
	  ○ Presence of fresh pustules (new appearance or worsening pustules)
	  ○ At least 5% body surface area (BSA) with erythema and the presence of pustules
	  ○ Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate)
	  ○ GPPPGA pustulation sub-score of at least 2 (mild)
	• Patient has failed an adequate trial*, or patient has a contraindication or intolerance to, at least 1 of the following:
	  ○ Methotrexate
	  ○ Acitretin
	  ○ Cyclosporine
	• Patient has failed an adequate trial*, or patient has a contraindication or intolerance to 2 of the following:
	  ○ Infliximab
	  ○ Adalimumab product
	  ○ Secukinumab
	• Patient has not received an infusion of spesolimab-sbzo previously for the same GPP flare
	*Adequate trial duration is defined as 6 weeks for systemic non-biologics and 12 weeks for biologics

DRUG NAME	COVERAGE CRITERIA

	Quantity Limit:
	• **IV formulation is limited to 900 mg once per week for two weeks**
	• **SQ formulation:**
	  ○ **Induction: 600 mg at week 0**
	  ○ **Maintenance: 300 mg starting at week 4 then every 4 weeks thereafter**

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday from 8 a.m. to 5 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee