AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Spevigo

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Dose: _____ 10. Directions: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: _____

Clinical Information

1. Does the beneficiary have a diagnosis of generalized pustular psoriasis (GPP)? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Does the beneficiary have any of the following conditions? Yes___ No___ **Please indicate which:** _____
   a. Synovitis-acne-pustulosis-hyperostosis-osteitis (SAPHO) syndrome
   b. Primary erythrodermic psoriasis vulgaris
   c. Primary plaque psoriasis vulgaris without presence of pustules or with pustules that are restricted to psoriatic plaques
   d. Drug-triggered acute generalized exanthematous pustulosis (AGEP)
4. Is the beneficiary experiencing an acute GPP flare of moderate to severe intensity? Yes___ No___
   4a. If yes, which of the following are they experiencing?
      ___ Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 (moderate)
      ___ Presence of fresh pustules (new or worsening), a GPPGA pustulation sub score of ≥ 2 (mild)
      ___ At least 5% of body surface area with erythema and the presence of pustules
5. Does the beneficiary have a history of hypersensitivity to any component of Spevigo? Yes___ No___
6. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
7. Will the beneficiary receive ongoing monitoring for the presence of TB during treatment? Yes___ No___
8. Does the beneficiary have active infection, including clinically important, localized infections? Yes___ No___
9. Will the beneficiary avoid concomitant use with TNF-α inhibitor (e.g., adalimumab, infliximab), biologic response modifier (e.g., apremilsat, upadacitinib), or systemic immunosuppressant (e.g., retinoid, cyclosporine, methotrexate)? Yes___ No___
10. Has the beneficiary received a live virus vaccine in the last 6 weeks? Yes___ No___
11. Will the beneficiary receive live vaccines during Spevigo therapy? Yes___ No___
12. Is the beneficiary on another injectable immunomodulator? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

8/11/2025