



Drug Coverage Policy

Effective Date05/15/2025
Coverage Policy Number.....IP0501
Policy Title.....Spevigo Intravenous
Prior Authorization Policy

Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy

- Spevigo® (spesolimab-sbzo intravenous infusion - Boehringer Ingelheim)

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

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Spevigo, an interleukin-36 receptor antagonist, is indicated for the treatment of generalized pustular psoriasis in adults and pediatric patients ≥ 12 years old and ≥ 40 kilogram (kg).¹

Spevigo intravenous (IV) use is only for the treatment of generalized pustular psoriasis flares. IV infusion of Spevigo is only to be administered by a healthcare professional in a healthcare setting.¹

Dosing Information

Spevigo is given as a single 900 mg dose by intravenous (IV) infusion over 90 minutes. If the generalized pustular psoriasis flare symptoms persist, an additional 900 mg dose given IV (over 90 minutes) may be administered one week after the initial dose.¹

Guidelines

The National Psoriasis Foundation has written a consensus statement for generalized pustular psoriasis (2024). The statement strongly advocates for timely access to FDA approved therapy for generalized pustular psoriasis because delays can increase the risk of mortality in patients.² The statement states that Spevigo is the first FDA-approved treatment that is highly effective in the treatment of generalized pustular psoriasis flares in adults. Timely access to approved therapies is critical to reducing morbidity and mortality in patients presenting with generalized pustular psoriasis. Treatment guidelines from the Medical Board of the National Psoriasis Foundation (2012) address the management of generalized pustular psoriasis in different clinical scenarios.³ Recommended therapies include acitretin, cyclosporine, methotrexate, and infliximab for adults with generalized pustular psoriasis as first-line therapy. Second-line therapy includes Humira, Enbrel, topical therapy (e.g. corticosteroids, calcipotriene, and tacrolimus), and PUVA (psoralen and ultraviolet A). There are also separate recommendations for pediatric and pregnant patients.

Coverage Policy

POLICY STATEMENT

Prior Authorization is required for benefit coverage of Spevigo. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Extended approvals are allowed if the patient continues to meet the Criteria and Dosing. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for 1 month (30 days). Because of the specialized skills required for evaluation and diagnosis of patients treated with Spevigo approval requires Spevigo to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Spevigo intravenous is considered medically necessary when the following are met:

FDA-Approved Indication

- 1. Generalized Pustular Psoriasis Flare.** Approve for up to two doses if the patient meets ALL of the following (A, B, C, D, E and F):
 - A)** Patient is ≥ 12 years of age; AND
 - B)** Patient weighs ≥ 40 kilograms (kg); AND
 - C)** Patient is experiencing a flare of a moderate-to-severe intensity; AND
 - D)** Patient meets ONE of the following (i or ii):
 - i.** Patient is not currently receiving Spevigo subcutaneous injection and meets ALL of the following (a, b, c, and d):
 - a)** Patient has Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 points; AND

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

HCPCS Codes	Description
J1747	Injection, spesolimab-sbzo, 1 mg (Code effective 04/01/2023)

References

1. Spevigo® intravenous infusion and subcutaneous injection [prescribing information]. Ridgefield, CT: Boehringer Ingelheim; March 2024.
2. Armstrong AW, Elston CA, Elewski BE. Generalized pustular psoriasis: A consensus statement from the National Psoriasis Foundation. *J Am Acad Dermatol.* 2024; 90(4):727-730.
3. Robinson A, Van Voorhees AS, Hsu S, et al. Treatment of pustular psoriasis: from the medical board of the National Psoriasis Foundation. *J Am Acad Dermatol.* 2012;67(2):279-288.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	<p>Updated policy title to Inflammatory Conditions – Spevigo Intravenous. Previously it was titled Spesolimab.</p> <p>Generalized Pustular Psoriasis Flare: The word “flare” was added to the condition of approval. The age requirement was changed from ≥ 18 years of age to ≥ 12 years of age. The weight requirement of ≥ 40 kilogram (kg) was added. Clarification was added that the following criteria apply to a patient who is not currently taking Spevigo subcutaneous: patient has Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 points; and patient has a GPPGA pustulation subscore of ≥ 2 points; and patient has new or worsening pustules; and patient has erythema and pustules which affects ≥ 5% of body surface area. Criteria was added for patient currently taking Spevigo subcutaneous which are: patient has had an increase in GPPGA total score of ≥ 2 points and patient has GPPGA pustulation subscore of ≥ 2 points. Reference to Spevigo was reworded to Spevigo intravenous in the following criterion “if patient has already received Spevigo intravenous (IV), patient has <u>not</u> already received two doses of Spevigo IV for treatment of the current flare”. The following criterion was reworded from “if this is a new flare” to state “if patient has previously received two doses of Spevigo IV” at least 12 weeks have elapsed since the last dose of Spevigo. The authorization duration was updated to be up to two doses, it was previously 3 months.</p>	7/15/2024

Selected Revision	Updated policy title from “Inflammatory Conditions – Spevigo Intravenous” to “Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy”.	11/01/2024
Annual Revision	No criteria changes	05/15/2025

The policy effective date is in force until updated or retired.

APPENDIX

	Mechanism of Action	Examples of Inflammatory Indications*
Biologics		
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF	AS, CD, JIA, PsO, PsA, RA, UC
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF	AS, CD, nr-axSpA, PsO, PsA, RA
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF	AS, JIA, PsO, PsA
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF	AS, CD, PsO, PsA, RA, UC
Simponi®, Simponi® Aria™ (golimumab SC injection, golimumab IV infusion)	Inhibition of TNF	SC formulation: AS, PsA, RA, UC
		IV formulation: AS, PJIA, PsA, RA
Actemra® (tocilizumab IV infusion, tocilizumab SC injection)	Inhibition of IL-6	SC formulation: PJIA, RA, SJIA
		IV formulation: PJIA, RA, SJIA
Kevzara® (sarilumab SC injection)	Inhibition of IL-6	RA
Orencia® (abatacept IV infusion, abatacept SC injection)	T-cell costimulation modulator	SC formulation: JIA, PsA, RA
		IV formulation: JIA, PsA, RA
Rituximab IV Products (Rituxan®, biosimilars)	CD20-directed cytolytic antibody	RA
Kineret® (anakinra SC injection)	Inhibition of IL-1	JIA [^] , RA
Stelara® (ustekinumab SC injection, ustekinumab IV infusion)	Inhibition of IL-12/23	SC formulation: CD, PsO, PsA, UC
		IV formulation: CD, UC
Siliq™ (brodalumab SC injection)	Inhibition of IL-17	PsO
Cosentyx® (secukinumab SC injection)	Inhibition of IL-17A	AS, ERA, nr-axSpA, PsO, PsA
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A	AS, nr-axSpA, PsO, PsA
Ilumya™ (tildrakizumab-asmn SC injection)	Inhibition of IL-23	PsO
Skyrizi® (risankizumab-rzaa SC injection, risankizumab-rzaa IV infusion)	Inhibition of IL-23	SC formulation: CD, PsA, PsO
		IV formulation: CD
Tremfya™ (guselkumab SC injection)	Inhibition of IL-23	PsO
Entyvio™ (vedolizumab IV infusion)	Integrin receptor antagonist	CD, UC

* Not an all-inclusive list of indications (e.g., oncology indications and rare inflammatory conditions are not listed). Refer to the prescribing information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; AS – Ankylosing spondylitis; CD – Crohn’s disease; JIA – Juvenile idiopathic arthritis; PsO – Plaque psoriasis; PsA – Psoriatic arthritis; RA – Rheumatoid arthritis; UC – Ulcerative colitis; nr-axSpA – Non-radiographic axial spondyloarthritis; IV – Intravenous, PJIA – Polyarticular juvenile idiopathic arthritis; IL – Interleukin; SJIA – Systemic juvenile idiopathic arthritis; [^] Off-label use of Kineret in JIA supported in guidelines; ERA – Enthesitis-related arthritis; DMARD – Disease-modifying antirheumatic drug; PDE4 – Phosphodiesterase 4; JAK – Janus kinase; AD – Atopic dermatitis.

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