



4/2/2026
Prior Authorization
Internal Use Only
<b>JOHNS HOPKINS HEALTH PLANS</b> Spevigo - Priority Partners MCO
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at <b>1-410-424-4607</b> . Please contact Johns Hopkins Health Plans at <b>1-888-819-1043</b> with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Spevigo - Priority Partners MCO.

Drug Name (select from list of drugs shown) Spevigo (spesolimab-sbzo)
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Quantity	Frequency	Strength
Route of Administration	Expected Length of Therapy	

Patient Information	
Patient Name:	_____
Patient ID:	_____
Patient Group No.:	_____
Patient DOB:	_____
Patient Phone:	_____

Prescribing Physician	
Physician Name:	_____
Physician Phone:	_____
Physician Fax:	_____
Physician Address:	_____
City, State, Zip:	_____

<b>Diagnosis:</b> _____	<b>ICD Code:</b> _____
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Comments: _____
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Please circle the appropriate answer for each question.

1. Does the patient have an active tuberculosis (TB) infection?	<input type="checkbox"/> Y <input type="checkbox"/> N
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[If yes, no further questions.]
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2. Does the patient have severe or life-threatening hypersensitivity to spesolimab-sbzo or to any of the excipients in the requested medication?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
3. Will the requested medication be used concurrently with any other biologic drug or targeted synthetic drug for the same indication?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
4. Will the requested medication be used for any indications that are not Food and Drug Administration (FDA)-approved or guideline-supported?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
5. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.	
[If no, skip to question 8.]	
6. Is the patient experiencing a flare?	<input type="checkbox"/> Y <input type="checkbox"/> N
[If yes, no further questions.]	
7. Has the patient achieved or maintained a positive clinical response, evidenced by low disease activity or improvement in signs and symptoms of the condition?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[No further questions.]	
8. Does the patient have a history of generalized pustular psoriasis (GPP) [either relapsing (greater than 1 episode) or persistent (greater than 3 months)]?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
9. Is the patient experiencing a flare at the time of request?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, no further questions.]	
10. Does the patient a history of at least two moderate-to-severe GPP flares (e.g., at least 5% body surface area is covered with erythema and the presence of pustules: Generalized Pustular Psoriasis Physician Global Assessment [GPPPGA] total score of greater than or equal to 3)?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If yes, skip to question 12.]	
11. Does the patient have a history of flaring while on concomitant treatment (e.g., retinoids, methotrexate, cyclosporine)?	<input type="checkbox"/> Y <input type="checkbox"/> N

NOTE: Submission of medical records is required.	
[If no, no further questions.]	
12. Does the patient currently have clear to almost clear skin?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
13. Has the patient had a negative tuberculosis (TB) test (which can include a tuberculosis skin test [TST] or an interferon-gamma release assay [IGRA] within 12 months of initiating therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
14. Does the patient weigh 40 kg or more?	<input type="checkbox"/> Y <input type="checkbox"/> N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
15. Is the patient 12 years of age or older?	<input type="checkbox"/> Y <input type="checkbox"/> N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>