TRICARE Prior Authorization Request Form for
spesolimab-sbzo (**Spevigo**)

JOHNS HOPKINS
HEALTH PLANS
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USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial Prior authorization expires after 1 year. PA approval is required for renewal.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID #: _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose **"No" if the patient did not previously have a TRICARE approved PA for the requested medication.***	☐ Yes (subject to verification) Proceed to question **18**	☐ No **Proceed to question 2**
2. Is the patient 12 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient weight 40 kilograms or greater?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a dermatologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have generalized pustular psoriasis?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

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6. Is the patient currently experiencing a flare?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **7**
7. Does the patient have history of at least two generalized pustular psoriasis flares of moderate-to-severe intensity in the past while on biologic suppressive maintenance therapy?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of 0 or 1?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the prescriber acknowledge that Humira is the Department of Defense's preferred targeted biologic agent?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **13**	☐ No Proceed to question **11**
11. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **13**	☐ No Proceed to question **12**
12. Does the patient have a contraindication to Humira?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Has the patient had an inadequate response to Cosentyx?	☐ Yes Proceed to question **16**	☐ No Proceed to question **14**
14. Has the patient experienced an adverse reaction to Cosentyx that is not expected to occur with the requested agent?	☐ Yes Proceed to question **16**	☐ No Proceed to question **15**
15. Does the patient have a contraindication to Cosentyx?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient had had an inadequate response to non-biologic systemic therapy. (For example, cyclosporine, methotrexate, acitretin, isotretinoin, systemic glucocorticoids, or mycophenolate)?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**

17. Will the requested drug be used concomitantly with other TIBs (Non-Tumor Necrosis Factor Inhibitors) including, but not limited to: certolizumab (Cimzia), etanercept (Enbrel), infliximab (Remicade), ustekinumab (Stelara), secukinumab (Cosentyx), ixekizumab (Taltz), guselkumab (Tremfya), tildrakizumab (Ilumya), risankizumab (Skyrizi)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
18. Has the patient had a documented reduction in generalized pustular psoriasis symptoms?	☐ Yes **Sign and date below**	☐ No Proceed to question **19**
19. Has the patient had a reduction in generalized pustular psoriasis flares?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[13 November 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: