spesolimab-sbzo (Spevigo)

Commercial Medical Benefit Drug Policy

Place of Service
Infusion Center Administration
Office Administration
Outpatient Facility Infusion Administration

Drug Details

USP Category: IMMUNOLOGICAL AGENTS
Mechanism of Action: Interleukin-36 receptor antagonist
HCPCS:
J1747:Injection, spesolimab-sbzo, 1 mg
How Supplied:

- 450 mg/7.5 mL (60 mg/mL) solution in a single-dose vial
- 150 mg/mL 2 single-dose prefilled syringes
- 300 mg/mL preferred syringes

Condition(s) listed in policy *(see coverage criteria for details)*

- Generalized Pustular Psoriasis, treatment and prevention

Any condition not listed in this policy requires a review to confirm it is medically necessary. For conditions that have not been approved for intended use by the Food and Drug Administration (i.e., off-label use), the criteria outlined in the Health and Safety Code section 1367.21 must be met.

Special Instructions and Pertinent Information

Provider must submit documentation (such as office chart notes, lab results or other clinical information) to ensure the member has met all medical necessity requirements.

The member's specific benefit may impact drug coverage. Other utilization management processes, and/or legal restrictions may take precedence over the application of this clinical criteria.

For billing purposes, drugs must be submitted with the drug's assigned HCPCS code (as listed in the drug policy) and the corresponding NDC (national drug code). An unlisted, unspecified, or miscellaneous code should not be used if there is a specific code assigned to the drug.

Spevigo given by intravenous (IV) injection and Spevigo 600 mg (loading dose) given subcutaneously are administered by a healthcare provider and are managed under the Medical Benefit policy. Spevigo 300 mg given subcutaneously can be self-administered and obtained through the patient's pharmacy benefit. Please refer to the "Self-Administered Drugs" medical benefit drug. policy for more information.

Coverage Criteria
The following condition(s) require Prior Authorization/Preservice.

Generalized Pustular Psoriasis, treatment and prevention
Meets medical necessity if all the following are met:
1. Prescribed by or in consultation with a dermatologist

2. Patient is 12 years of age or older and weighs 40 kg or more
3. Either of the following:
    1. Being used to treat a GPP flare
    2. Being used to prevent a GPP flare and all the following:
        i. Being used for a loading dose (i.e., 600mg), and
        ii. Patient has not received IV treatment for a GPP flare in the past 4 weeks

Covered Doses:
Treatment: 900 mg IV for one dose followed by an additional 900 mg dose a week later if needed
Prevention: 600 mg SC for one dose. Subsequent SC doses of 300 mg can be self-given or given by a caregiver in the home. Drugs that can be given at home can be requested from your Pharmacy Benefit.

Coverage Period:
Treatment: Cover up to 2 doses per flare
Prevention: Cover for 1 dose

ICD-10:
L40.1

References

1. Spevigo (spesolimab) [prescribing information]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals Inc; March 2024.

Review History

Date of Last Annual Review: 4Q2024
Changes from previous policy version:

- No clinical changes following annual review.

Blue Shield of California Medication Policy to Determine Medical Necessity
Reviewed by P&T Committee