Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Spevigo
(spesolimab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ☐ Spevigo ICD10:

Dose and Quantity: Duration of therapy: J-code:
Frequency of administration:

Is this a new flare? ☐ Yes ☐ No

Has it been at least 12 weeks since the last treatment course of Spevigo? ☐ Yes ☐ No

Please provide the dates your patient has received Spevigo:

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) for the treatment of generalized pustular psoriasis include Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Otezla, Siliq, Skyrizi subcutaneous, Stelara subcutaneous, Taltz and Tremfya. Which of the following best describes your patient's situation?
☐ The patient is NOT taking any other biologic or tsDMARD for the treatment of generalized pustular psoriasis at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using
☐ The patient is currently on another biologic or tsDMARD for the treatment of generalized pustular psoriasis, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD for the treatment of generalized pustular psoriasis, and the requested drug will be added. The patient may continue to take both drugs together
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD for the treatment of generalized pustular psoriasis
☐ other/unknown

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:

☐ Generalized Pustular Psoriasis
☐ Plaque Psoriasis
☐ other (please specify):

Clinical Information:

Is the individual having a moderate-to-severe flare? ☐ Yes ☐ No

Does the individual have new or worsening pustules? ☐ Yes ☐ No

Does the individual have erythema (reddening of the skin) and pustules affecting at least 5% of their body surface area (BSA)? ☐ Yes ☐ No

Is this drug being prescribed by, or in consultation with, a dermatologist? ☐ Yes ☐ No

Additional Information Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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