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 vial for intravenous
☐ Spevigo subcutaneous

ICD10:

Dose and Quantity:
Frequency of administration:

Duration of therapy:

J-code:

How much does the patient weigh?
☐ Less than 40 kilograms (kg)
☐ 40 kilograms (kg) or more

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

What is the indication or diagnosis?

☐ Generalized Pustular Psoriasis Flare
☐ Plaque Psoriasis
☐ Other

Clinical Information:

Will the requested medication be used in combination with another biologic prescribed for treatment of generalized pustular psoriasis? Please Note: Patients with concomitant plaque psoriasis and generalized pustular psoriasis may be receiving a biologic for treatment of plaque psoriasis.

☐ Yes, Biologic (for example, an adalimumab product [Humira, biosimilar], Cimzia, an etanercept SC product [Enbrel, biosimilar], an infliximab IV product [Remicade, biosimilar], Simponi SC, Icotyde, an ustekinumab product [Stelara SC, biosimilar], Siliq, Bimzelx, Cosentyx SC, Taltz, Ilumya, Skyrizi SC, or Tremfya SC)

☐ No, the requested medication will NOT be used in combination with another biologic prescribed for treatment of generalized pustular psoriasis. Please Note: Patients with concomitant plaque psoriasis and generalized pustular psoriasis may be receiving a biologic for treatment of plaque psoriasis.

Does the patient weigh greater than or equal to 40 kilograms (kg)?	☐ Yes ☐ No
Is the requested medication being prescribed by or in consultation with a dermatologist?	☐ Yes ☐ No
Is the patient experiencing a flare of moderate-to-severe intensity?	☐ Yes ☐ No
Has the patient already received Spevigo intravenous?	☐ Yes ☐ No
Has the patient already received two doses of Spevigo intravenous for treatment of the current flare?	☐ Yes ☐ No
Has the patient already received two doses of Spevigo intravenous for a previous flare?	☐ Yes ☐ No
Have at least 12 weeks elapsed since the last dose of Spevigo?	☐ Yes ☐ No
Is the request for treatment of a new flare?	☐ Yes ☐ No
Have at least 12 weeks elapsed since the last dose of Spevigo?	☐ Yes ☐ No
Have at least 7 days elapsed since the last dose of Spevigo?	☐ Yes ☐ No

Additional Information

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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