UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1446-2
Program	Prior Authorization/Notification
Medication	*Spevigo® (spesolimab-sbzo) injection *This program applies to the subcutaneous formulations of Spevigo
P&T Approval Date	5/2024, 5/2025
Effective Date	7/1/2025

1. Background:

Spevigo is an interleukin-36 receptor antagonist indicated for the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older and weighing at least 40 kg.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Spevigo** will be approved based upon **both** of the following criteria:

   a. Diagnosis of generalized pustular psoriasis (GPP)

   -AND-

   b. Used for the treatment of GPP

   Authorization will be issued for 12 months.

B. Reauthorization

1. **Spevigo** will be approved based upon the following criterion:

   a. Documentation of positive clinical response to therapy

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity, and/or Step Therapy may be in place.

4. References:

1. Spevigo [package insert]. Ridgefield, CT: Boehringer Ingelheim Pharmaceuticals, Inc.; March 2024.

Program	Prior Authorization/Notification – Spevigo® (spesolimab-sbzo)
Change Control	
5/2024	New program.
5/2025	Annual review. Updated coverage criteria wording without change to clinical intent.