

Clinical Policy: Spesolimab-sbzo (Spevigo)

Reference Number: CP.PHAR.606

Effective Date: 03.01.23

Last Review Date: 02.23

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Spesolimab-sbzo (Spevigo®) is an interleukin-36 receptor antagonist.

FDA Approved Indication(s)

Spevigo is indicated for the treatment of generalized pustular psoriasis (GPP) flares in adults.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Spevigo is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Generalized Pustular Psoriasis (must meet all):**

1. Diagnosis of GPP;
2. Documentation of GPP flares of moderate-to-severe intensity;
3. Prescribed by or in consultation with a dermatologist;
4. Age \geq 18 years;
5. Failure of a \geq 3 consecutive month trial of one of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated: methotrexate, cyclosporine, acitretin;
6. Spevigo is not prescribed concurrently with biological disease-modifying antirheumatic drug or Janus kinase inhibitors (*see Section III: Diagnosis/Indications for which coverage is NOT authorized*);
7. Dose does not exceed 900 mg (2 vials) one time, followed by an optional second 900 mg (2 vials) dose 1 week later if flare symptoms persist.

Approval duration: 1 month

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Generalized Pustular Psoriasis

1. Re-authorization is not permitted. Members must meet the initial approval criteria.
Approval duration: Not applicable

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 2 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.
- B. Combination use with biological disease-modifying antirheumatic drugs (bDMARDs) or potent immunosuppressants, including but not limited to any tumor necrosis factor (TNF) antagonists [e.g., Cimzia[®], Enbrel[®], Humira[®], Simponi[®], Avsola[™], Inflectra[™], Remicade[®], Renflexis[™]], interleukin agents [e.g., Arcalyst[®] (IL-1 blocker), Ilaris[®] (IL-1 blocker), Kineret[®] (IL-1RA), Actemra[®] (IL-6RA), Kevzara[®] (IL-6RA), Stelara[®] (IL-12/23 inhibitor), Cosentyx[®] (IL-17A inhibitor), Taltz[®] (IL-17A inhibitor), Siliq[™] (IL-17RA), Ilumya[™] (IL-23 inhibitor), Skyrizi[™] (IL-23 inhibitor), Tremfya[®] (IL-23 inhibitor)], Janus kinase inhibitors (JAKi) [e.g., Xeljanz[®]/Xeljanz[®] XR, Cibinqo[™],

Olumiant[™], Rinvoq[™], anti-CD20 monoclonal antibodies [Rituxan[®], Riabni[™], Ruxience[™], Truxima[®], Rituxan Hycela[®]], selective co-stimulation modulators [Orencia[®]], and integrin receptor antagonists [Entyvio[®]] because of the additive immunosuppression, increased risk of neutropenia, as well as increased risk of serious infections.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DRESS: drug reaction with eosinophilia or systemic symptoms

FDA: Food and Drug Administration

GPP: generalized pustular psoriasis

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
acitretin (Soriatane [®])*	0.5 – 1 mg/kg PO QD	1 mg/kg/day
cyclosporine (Sandimmune [®] , Neoral [®])*	2.5 – 5 mg/kg PO QD	5 mg/kg/day
methotrexate (Rheumatrex [®])*	15 – 25 mg/week IM or SC	30 mg/week

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): severe or life-threatening hypersensitivity to spesolimab-sbzo or any of the excipients in Spevigo, drug reaction with eosinophilia or systemic symptoms (DRESS)
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
GPP	900 mg IV infusion once; if flare symptoms persist additional 900 mg dose may be administered one week after initial dose.	See dosing regimen

VI. Product Availability

Single-dose vial: 450 mg/7.5 mL (60 mg/mL)

VII. References

1. Spevigo Prescribing Information. Ridgefield, CT. Boehringer Ingelheim Pharmaceuticals, Inc.; September 2022. Available at: www.spevigo.com. Accessed September 13, 2022.
2. Bachelez H, Choon S.E, Marrakchi S, et al. Trial of spesolimab for generalized pustular psoriasis. N Engl J Med 2021;385:2431-40. <https://doi.org/10.1056/NEJMoa2111563>

3. Jruegar J, Puig Lluís, Diamant Thaç. Treatment options and goals for patients with generalized pustular psoriasis. Am J Clin Dermatol 23 (Suppl 1), 51–64 (2022). <https://doi.org/10.1007/s40257-021-00658-9>.
4. Spevigo Drug Monograph. Clinical Pharmacology. Accessed September 2022. www.clinicalkeys.com/pharmacology.
5. Fujita H, Terui T, Hayma K, et al. Japanese guidelines for the management and treatment of generalized pustular psoriasis: The new pathogenesis and treatment of GPP. J Dermatol 45: 1235-1270. <https://doi.org/10.1111/1346-8138.14523>

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3590	Unclassified biologics
C9399	Unclassified drugs or biologicals
J1747	Injection, spesolimab-sbzo, 1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.22.22	02.23
Added HCPCS code [J1747].	04.17.23	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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