South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029.
Mon-Sat: 7am to 7pm Central

Spevigo® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe generalized pustular psoriasis (GPP)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have presence of fresh pustules (new appearance or worenign pustules)? ❑ **Yes** ❑ **No**

Is at least 5% of body surface area covered with erythema and presence of pustules? ❑ **Yes** ❑ **No**

What is the Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score? _____

What is the patient's weight? _____

Select if Spevigo is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Other _____

Will Spevigo be used in combination with another biologic agent or targeted immunomodulator? ❑ **Yes** ❑ **No**

Medication history:

Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? ❑ **Yes** ❑ **No**

Has the patient have a documented 14-day trial of a topical corticosteroid, pimecrolimus cream, tacrolimus ointment, or Eucrisa (crisaborole)? _____

_____

Quantity limit requests:

What is the quantity requested per TREATMENT? _____ syringe every _____ weeks

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.