

GCHP Medi-Cal Clinical Guidelines Spesolimab (Spevigo™)

PA Criteria	Criteria Details		
Covered Uses (FDA Approved Indication)	Generalized pustular psoriasis (GPP) flares.		
Exclusion Criteria	<ul style="list-style-type: none">Primary plaque psoriasis vulgaris without presence of pustules.Active, serious infection, latent (untreated) tuberculosis.		
Required Medical Information	<ul style="list-style-type: none">Clinic notes confirming the diagnosis of GPP flares.Not currently on retinoids, methotrexate, or cyclosporine prior to initiation of Spevigo™.Does not have an immediate life-threatening flare of GPP or requiring intensive care treatment.Patient does not have SAPHO syndrome (inflammatory bone disorders that may be associated with skin changes).		
Age Restriction	18 years of age and older		
Prescriber Restrictions	Prescribed or recommended by a dermatologist.		
Coverage Duration	Three months (maximum of two doses one week apart).		
Other Criteria / Information	Criteria adapted from DHCS April 2024		
	HCPCS	Description	Dosing, Units
	J1747	Injection, spesolimab-sbzo, 1mg (Spevigo™)	900mg IV once; if flare persists, an additional 900mg IV may be given one week later.

STATUS	DATE REVISED	REVIEW DATE	APPROVED / REVIEWED BY	EFFECTIVE DATE
Created	5/1/2024	5/1/2024	Lily Yip, Director of Pharmacy Services; Yoonhee Kim, Clinical Programs Pharmacist	N/A
Approved	N/A	5/15/2024	Pharmacy & Therapeutics (P&T) Committee	3/1/2025
Approved	N/A	7/18/2024	Medical Advisory Committee (MAC)	3/1/2025