



UTILIZATION MANAGEMENT MEDICAL POLICY

POLICY: Inflammatory Conditions – Spevigo Intravenous Utilization Management Medical Policy

- Spevigo® (spesolimab-sbzo intravenous infusion – Boehringer Ingelheim)

REVIEW DATE: 06/10/2026

OVERVIEW

Spevigo, an interleukin-36 receptor antagonist, is indicated for the treatment of **generalized pustular psoriasis** in adults and pediatric patients ≥ 12 years old weighing ≥ 40 kg.¹

Spevigo intravenous (IV) is only indicated for the treatment of generalized pustular psoriasis flares.¹ IV infusion of Spevigo is only to be administered by a healthcare professional in a healthcare setting. Spevigo is also available as a subcutaneous injection for the treatment of generalized pustular psoriasis when the patient is not experiencing a flare.

Dosing Information

Spevigo is given as a single 900 mg dose by IV infusion over 90 minutes.¹ If the generalized pustular psoriasis flare symptoms persist, an additional 900 mg dose given IV (over 90 minutes) may be administered one week after the initial dose.

Guidelines

The National Psoriasis Foundation has written a consensus statement for generalized pustular psoriasis (2024).² The statement strongly advocates for timely access to FDA-approved therapy for generalized pustular psoriasis because delays can increase the risk of mortality in patients. It is noted that Spevigo is the first FDA-approved treatment that is highly effective in the treatment of generalized pustular psoriasis flares in adults. Timely access to approved therapies is critical to reducing morbidity and mortality in patients presenting with generalized pustular psoriasis.

POLICY STATEMENT

Prior Authorization is recommended for medical benefit coverage of Spevigo intravenous. Approval is recommended for those who meet the **Criteria** and **Dosing** for the listed indication. Requests for doses outside of the established dosing documented in this policy will be considered on a case-by-case basis by a clinician (i.e., Medical Director or Pharmacist). All approvals are provided for 1 month (30 days). Because of the specialized skills required for evaluation and diagnosis of patients treated with Spevigo intravenous, approval requires Spevigo intravenous to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Spevigo intravenous is recommended in those who meet the following criteria:

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FDA-Approved Indication

1. **Generalized Pustular Psoriasis Flare.** Approve for 1 month if the patient meets ALL of the following (A, B, C, D and E):
 - A) Patient meets ONE of the following (i or ii):
 - i. Patient is ≥ 18 years of age; OR
 - ii. Patient meets BOTH of the following (a and b):
 - a) Patient is ≥ 12 years to ≤ 17 years of age; AND
 - b) Patient weighs ≥ 40 kilograms (kg); AND
 - B) According to the prescriber, patient is treating a current flare of moderate to severe intensity; AND
 - C) For treatment of the current flare, the patient has not already received two or more doses of Spevigo intravenous; AND
 - D) If the patient has received Spevigo intravenous for the treatment of a previous flare, at least 12 weeks have elapsed since the last dose of Spevigo intravenous; AND
 - E) The medication is prescribed by or in consultation with a dermatologist.

Dosing. Approve 900 mg per dose administered by intravenous infusion for up to two doses per flare.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Spevigo intravenous is not recommended in the following situations:

1. **Concomitant use with Another Biologic Prescribed for Treatment of Generalized Pustular Psoriasis.** Although not approved, there are case reports documenting use of some biologics approved for plaque psoriasis (see [Appendix](#) for examples) for treatment of generalized pustular psoriasis. In the pivotal study, patients were required to discontinue therapy for generalized pustular psoriasis prior to receiving Spevigo.
Note: Patients with concomitant plaque psoriasis and generalized pustular psoriasis may be receiving a biologic for treatment of plaque psoriasis.
2. **Plaque Psoriasis.** Spevigo has not been studied in patients with plaque psoriasis without generalized pustular psoriasis.
Note: Patients with concomitant plaque psoriasis and generalized pustular psoriasis may be reviewed under the generalized pustular psoriasis criteria above.
3. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

1. Spevigo® intravenous infusion and subcutaneous injection [prescribing information]. Ridgefield, CT: Boehringer Ingelheim; March 2026.
2. Armstrong AW, Elston CA, Elewski BE. Generalized pustular psoriasis: A consensus statement from the National Psoriasis Foundation. *J Am Acad Dermatol.* 2024; 90(4):727-730.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	The name of the policy was changed to Inflammatory Conditions – Spevigo Intravenous UM Medical Policy. Previously it was Inflammatory Conditions – Spevigo UM Medical Policy. Generalized Pustular Psoriasis Flare: The word “flare” was added the condition of approval. The age requirement was changed from ≥ 18 years of age to ≥ 12 years of age. The weight requirement of ≥ 40 kilogram (kg) was added. Clarification was added that the following criteria apply to a patient who is not currently taking Spevigo subcutaneous: patient has Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 points; and patient has a GPPGA pustulation subscore of ≥ 2 points; and patient has new or worsening pustules; and patient has erythema and pustules which affects $\geq 5\%$ of body surface area. Criteria was added for patient currently taking Spevigo subcutaneous which are: patient has had an increase in GPPGA total score of ≥ 2 points and patient has GPPGA pustulation subscore of ≥ 2 points. Reference to Spevigo was reworded to Spevigo intravenous in the following criterion “if patient has already received Spevigo intravenous (IV), patient has <u>not</u> already received two doses of Spevigo IV for treatment of the current flare”. The following criterion was reworded from “if this is a new flare” to state “if patient has previously received two doses of Spevigo IV” at least 12 weeks have elapsed since the last dose of Spevigo.	04/10/2024
Annual Revision	No criteria changes.	04/09/2025
Annual Revision	No criteria changes. Appendix updated to only include biologics FDA approved for the treatment of plaque psoriasis.	04/29/2026
Early Annual Revision	Generalized Pustular Psoriasis Flare: Modified the weight requirement of ≥ 40 kilograms so that it only applies for patients ≥ 12 years to ≤ 17 years of age. Removed requirements for patients not currently receiving Spevigo subcutaneous that they have a Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 points; a GPPGA pustulation subscore of ≥ 2 points; that the patient has new or worsening pustules; and that the patient has erythema and pustules which affects $\geq 5\%$ of body surface area. Removed requirements for patients currently receiving Spevigo subcutaneous that they have a GPPGA total score of ≥ 2 points and a GPPGA pustulation subscore of ≥ 2 points.	05/13/2026
Early Annual Revision	The Policy Statement was revised to note that this policy applies to the Spevigo intravenous formulation. Generalized Pustular Psoriasis Flare: The approval duration was changed to 1 month; previously, it was up to two doses. Regarding the requirement that the patient is experiencing a flare of moderate to severe intensity, the phrase “according to the prescriber” was added; the phrase “experiencing” a flare was changed to “treating a current” flare. Regarding previous receipt of Spevigo intravenous, the requirements were divided into separate criterion. Regarding treatment of the current flare, the wording that the “patient has not already received two doses of Spevigo intravenous” was changed to “two or more doses of Spevigo intravenous.” The requirement that if the patient has previously received two doses of Spevigo intravenous at least 12 weeks have elapsed since the last dose of Spevigo was reworded to state “if the patient has received Spevigo intravenous for the treatment of a previous flare, at least 12 weeks have elapsed since the last dose of Spevigo intravenous.” Regarding Dosing, the following requirements were removed: 1) if a second doses is administered, 7 days elapse between the doses; and 2) if this is a new flare, at least 12 weeks have elapsed since the last dose of Spevigo. Also, regarding the approval of 900 mg per dose administered by intravenous infusion, the qualifier “for up to two doses per flare” was added.	06/10/2026

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APPENDIX

Examples of Biologics for Plaque Psoriasis*	Mechanism of Action
Adalimumab SC Products (Humira®, biosimilars)	Inhibition of TNF
Cimzia® (certolizumab pegol SC injection)	Inhibition of TNF
Etanercept SC Products (Enbrel®, biosimilars)	Inhibition of TNF
Infliximab IV Products (Remicade®, biosimilars)	Inhibition of TNF
Simponi® (golimumab SC injection)	Inhibition of TNF
Ustekinumab SC Products (Stelara® SC, biosimilars)	Inhibition of IL-12/23
Siliq® (brodalumab SC injection)	Inhibition of IL-17
Bimzelx® (bimekizumab SC injection)	Inhibition of IL-17A/17F
Cosentyx® (secukinumab SC injection)	Inhibition of IL-17A
Taltz® (ixekizumab SC injection)	Inhibition of IL-17A
Ilumya® (tildrakizumab-asmn SC injection)	Inhibition of IL-23
Skyrizi® (risankizumab-rzaa SC injection)	Inhibition of IL-23
Tremfya® (guselkumab SC injection)	Inhibition of IL-23

* Not an all-inclusive list of biologics indicated for psoriasis. Refer to the Prescribing Information for the respective agent for FDA-approved indications; SC – Subcutaneous; TNF – Tumor necrosis factor; IV – Intravenous; IL – Interleukin.