Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Spevigo

Member Information

1. Member Last Name: _____ 2. First Name: _____
3. Member ID #: _____ 4. Member Date of Birth: _____ 5. Member Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Reauthorization Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial Authorization Request:

1. Is the member age 18 or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of generalized pustular psoriasis (GPP)? ☐ **Yes** ☐ **No**
3 Does the member NOT have any of the following conditions: synovitis-acne-pustulosis-hyperostosis-osteitis (SAPHO) syndrome, primary erythrodermic psoriasis vulgaris, primary plaque psoriasis vulgaris without presence of pustules or with pustules that are restricted to psoriatic plaques, or drug-triggered acute generalized exanthematous pustulosis (AGEP)? ☐ **Yes** ☐ **No**
4. Is the member experiencing an acute GPP flare of moderate to severe intensity defined by all of the following: Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥2 (mild) and ≥ 5% of body surface area with erythema and the presence of pustules? ☐ **Yes** ☐ **No**
5. Does the member NOT have a history of hypersensitivity to any component of the product? ☐ **Yes** ☐ **No**
6. Has the member been evaluated and screened for the presence of latent tuberculosis (TB) prior to initiating treatment and will receive ongoing monitoring for presence of TB during treatment? ☐ **Yes** ☐ **No**
7 Does the member NOT have an active infection, including clinically important, localized infections? ☐ **Yes** ☐ **No**
8. Will the member NOT use the medication concomitantly with any of the following: TNT -a inhibitor (e.g., adalimumab, infliximab), biologic response modifier (e.g., apremilsat, Upadacitinib), or systemic immunosuppressant (e.g., retinoid, cyclosporine, methotrexate) ? ☐ **Yes** ☐ **No**
9. Has the member NOT received a live virus vaccine in the last 6 weeks and will NOT receive a live virus vaccine during therapy. ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.