spesolimab-sbzo (Spevigo ®)

Medicare Advantage Medical Policy # MA-105
Original Effective Date: 07/01/2025
Current Effective Date: 07/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Generalized Pustular Psoriasis Flare
Based on review of available data, the Health Plan may consider spesolimab (Spevigo®)‡ intravenous infusion for the treatment of generalized pustular psoriasis flare to be **eligible for coverage.****

Patient Selection Criteria
Coverage eligibility will be considered for spesolimab (Spevigo) intravenous infusion for the treatment of generalized pustular psoriasis flare when the following criteria are met:

- Patient has a diagnosis of generalized pustular psoriasis (GPP); AND
- Patient is 12 years of age or older; AND
- Patient weighs 40 kilograms or more; AND
- Patient is experiencing a flare of moderate to severe intensity; AND
- Patient has a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of ≥ 3 points; AND
- Patient has a GPPPGA pustulation sub score of ≥ 2 points; AND
- Patient has new or worsening pustules; AND
- Patient has erythema and pustules which affect ≥ 5% body surface area; AND
- Patient will not use more than two (2), 900 mg doses within a 12-week period for the current flare; AND
- Spevigo will not be used in combination with biologic therapies such as adalimumab (Humira®, Simandi®, adalimumab-adaz)‡, ixekizumab (Taltz®)‡ or secukinumab (Cosentyx™)‡, systemic therapies such as acitretin, cyclosporine, or methotrexate, or topical therapies such as corticosteroids, calcipotriene, or tacrolimus for the treatment of GPP; AND
- Patient has a negative TB test (e.g., purified protein derivative [PPD], blood test) prior to treatment.

Generalized Pustular Psoriasis Treatment
Based on review of available data, the Health Plan may consider spesolimab (Spevigo) subcutaneous injection for the treatment of generalized pustular psoriasis when not experiencing a flare to be **eligible for coverage.****

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Patient Selection Criteria
Coverage eligibility will be considered for spesolimab (Spevigo) subcutaneous injection for the treatment of generalized pustular psoriasis when not experiencing a flare when the following criteria are met:

- Patient has a diagnosis of generalized pustular psoriasis (GPP); AND
- Patient is 12 years of age or older; AND
- Patient weighs 40 kilograms or more; AND
- Patient has a history of at least two GPP flares of moderate to severe intensity in the past; AND
- Patient has a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of 0 or 1; AND
- Patient meets one of the following:
    - Patient has tried and failed (i.e., intolerance, inadequate response, or loss of response) treatment with at least ONE systemic therapy for GPP (i.e., methotrexate, acitretin, cyclosporine, infliximab, or other biologic agents such as adalimumab (Humira, Simandi, adalimumab-adaz), ixekizumab (Taltz) or secukinumab (Cosentyx) unless there is clinical evidence or patient history that suggests the use of these therapies will be ineffective or cause an adverse reaction to the patient; OR
    - Patient has received treatment with Spevigo intravenous infusion for GPP flare; AND
- Spevigo will not be used in combination with biologic therapies such as adalimumab (Humira, Simandi, adalimumab-adaz), ixekizumab (Taltz) or secukinumab (Cosentyx), systemic therapies such as acitretin, cyclosporine, or methotrexate, or topical therapies such as corticosteroids, calcipotriene, or tacrolimus for the treatment of GPP; AND
- Patient has a negative TB test (e.g., purified protein derivative [PPD], blood test) prior to treatment.

When Services Are Considered Not Medically Necessary

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) intravenous infusion when the patient is not experiencing a flare of moderate to severe intensity to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) intravenous infusion when the patient does not have a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of ≥ 3 points to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) intravenous infusion when the patient does not have a GPPPGA pustulation sub score of ≥ 2 points to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) intravenous infusion when the patient does not have erythema and pustules which affect ≥ 5% body surface area to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) subcutaneous injection when the patient does not have a history of at least two GPP flares of moderate to severe intensity in the past to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) subcutaneous injection when the patient does not have does not have a GPPPGA total score of 0 or 1 to be **not medically necessary.****

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) subcutaneous injection when the patient has not tried and failed (i.e., intolerance, inadequate response, or loss of response) treatment with at least ONE systemic therapy for GPP OR has not received treatment with Spevigo intravenous infusion for GPP flare to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) for any indication other than GPP to be **investigational.***

Based on review of available data, the Health Plan considers the use of spesolimab (Spevigo) when the patient selection criteria are not met (EXCEPT those denoted as not medically necessary**) to be **investigational.***

Background/Overview

Spevigo is an interleukin-36 receptor antagonist that is indicated for the treatment of generalized pustular psoriasis in adults and pediatric patients 12 years of age and older weighing at least 40 kilograms. It is available in both intravenous (IV) and subcutaneous (SC) formulations, which includes a 60 mg/ml vial and a 150 mg/ml single dose prefilled syringe. Spevigo IV is only to be used in GPP flares, while Spevigo SC is to be used for GPP when not experiencing a flare. The recommended dose of Spevigo IV for GPP flare is a single 900 mg dose administered over 90 minutes. If the symptoms of the flare continue to persist after the first IV administration, an additional dose may be given one week later. The recommended dose of Spevigo SC is a loading dose of 600 mg (four 150 mg injections) subcutaneously followed by 300 mg (two 150 mg injections) subcutaneously 4 weeks later and every 4 weeks thereafter. A subcutaneous loading dose is not required following treatment with Spevigo IV for GPP flare.

Generalized Pustular Psoriasis
Generalized pustular psoriasis is a rare and potentially life-threatening condition. It is characterized by unpredictable acute flares of widespread painful, sterile, visible pustules and red and tender skin which present with or without other systemic symptoms such as pain, fever, general malaise, fatigue, arthritis, rapid pulse loss, muscle weakness, and neutrophilic cholangitis. These flares can be spontaneous or triggered by a variety of causes including upper respiratory infection, stress, medications, medication withdrawal, or pregnancy. If left untreated, uncontrolled severe GPP flares can lead to complications such as hypotension, edema, electrolyte abnormalities, leukocytosis, sepsis, and renal, hepatic, respiratory, and heart failure. GPP may present as a relapsing disease with recurrent flares and no pustulation between flares or as a persistent disease with continuous pustulation and episodes of severe flares. Recommended therapies for the treatment of GPP include off-label use of retinoids, cyclosporine, and methotrexate. Biologics such as tumor necrosis factor (TNF) alpha inhibitors, IL-17 inhibitors, and IL-23 inhibitors have also been recommended for off-label use for GPP. Spevigo is the first FDA approved agent to be approved for GPP treatment and GPP flare prevention.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)
Spevigo is indicated for the treatment of generalized pustular psoriasis (GPP) in adults and pediatric patients 12 years of age and older weighing at least 40 kilograms.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

Intravenous Spevigo for Treatment of GPP Flare
A 12 week randomized, double-blind, placebo-controlled study (Study Effisayil-1) was conducted to evaluate the clinical efficacy and safety of intravenous Spevigo in adult subjects with flares of generalized pustular psoriasis (GPP). Subjects were randomized if they had a flare of GPP of moderate-to-severe intensity, as defined by:

- A Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate) [the total GPPPGA score ranges from 0 (clear) to 4 (severe)],
- The presence of fresh pustules (new appearance or worsening of pustules),
- GPPPGA pustulation sub score of at least 2 (mild), and
- At least 5% of body surface area covered with erythema and the presence of pustules.

Subjects were required to discontinue systemic and topical therapy for GPP prior to receiving study drug. A total of 53 subjects were randomized (2:1) to receive a single intravenous dose of 900 mg

Spevigo or placebo (administered over 90 minutes) during the double-blind portion of the study.

The primary endpoint of the study was the proportion of subjects with a GPPPGA pustulation sub score of 0 (indicating no visible pustules) at Week 1 after treatment. At the end of Week 1 (i.e. Day 8), 19 of 35 patients (54%) in the Spevigo group met the primary endpoint of GPPPGA pustulation subscore of 0, compared with one of 18 patients (6%) in the placebo group (difference, 49%; P <0.001).

In Study Effisayil-1, subjects in either treatment group who continued to experience flare symptoms at Week 1 were eligible to receive a single open-label intravenous dose of 900 mg of Spevigo (second dose and first dose for subjects in the Spevigo and placebo groups, respectively). At Week 1, 12 (34%) subjects and 15 subjects (83%) in the intravenous Spevigo and placebo groups, respectively, received open-label Spevigo. In subjects who were randomized to intravenous Spevigo and received an open-label dose of Spevigo at Week 1, 5 (42%) subjects had a GPPPGA pustulation sub score of 0 at Week 2 (one week after their second dose of Spevigo).

Subcutaneous Spevigo for Treatment of GPP When Not Experiencing a Flare
A randomized, double-blind, placebo-controlled study (Study Effisayil-2) evaluated the efficacy and safety of Spevigo for subcutaneous administration in adults and pediatric subjects (12 years of age and older and weighing at least 40 kg) with a history of at least two GPP flares of moderate-to-severe intensity in the past. Subjects were randomized if they had a GPPPGA total score of 0 or 1 at screening and randomization. Subjects were required to discontinue systemic and topical therapy for GPP prior to or at randomization. These subjects must have had a history of flaring while on concomitant treatment for GPP or a history of flaring upon dose reduction or discontinuation of these concomitant medications. A total of 123 subjects were randomized (1:1:1:1) to one of four treatment arms:

- Spevigo: 600 mg subcutaneous loading dose (LD) followed by 300 mg subcutaneously every 4 weeks
- Spevigo: 600 mg subcutaneous LD followed by 300 mg subcutaneously every 12 weeks
- Spevigo: 300 mg subcutaneous LD followed by 150 mg subcutaneously every 12 weeks
- Placebo: subcutaneous LD followed by subcutaneous treatment every 4 weeks

Subjects who experienced a GPP flare were eligible to receive up to two open-label intravenous doses of 900 mg Spevigo. Two (7%) subjects in the subcutaneous Spevigo 600 mg LD/300 mg every 4 weeks arm and 15 (48%) subjects in the placebo arm received intravenous Spevigo for treatment of GPP flare.

The primary endpoint of the study was the time to the first GPP flare up to Week 48 (defined by a GPPPGA pustulation sub score of ≥ 2 and an increase in GPPPGA total score by ≥ 2 from baseline). The key secondary endpoint was the occurrence of at least one GPP flare up to Week 48.
A total of 35 of 123 patients experienced a generalized pustular psoriasis flare at Week 48, which included 23% of patients (n = 7/31) in the low-dose Spevigo group (300 mg subcutaneous LD

followed by 150 mg subcutaneously every 12 weeks) , 29% of patients (n = 9/31) in the medium-dose Spevigo group (600 mg subcutaneous LD followed by 300 mg subcutaneously every 12 weeks), 10% of patients (n = 3/30) in the high-dose Spevigo group (600 mg subcutaneous LD followed by 300 mg subcutaneously every 4 weeks), and 52% of patients (n = 16/31) in the placebo group. Spevigo 600 mg subcutaneous LD followed by 300 mg subcutaneously every 4 weeks demonstrated statistically significant improvement vs. placebo on the key secondary endpoint of occurrence of at least one generalized pustular psoriasis flare by Week 48 (measured as flare vs. no flare) [P = 0.0013].

References

1. Spevigo [package insert]. Boehringer Ingelheim Pharmaceuticals, Inc. Ridgefield, Connecticut. March 2024.
2. Spevigo Subcutaneous Drug Evaluation. Express Scripts. April 2024.
3. Spevigo (spesolimab-sbzo). New Drug Review. IPD Analytics. November 2022.

Policy History

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Current Effective Date: 07/01/2025
04/15/2025 UM Committee review and approval. New policy.
Next Scheduled Review Date: 04/2026

Coding

The five character codes included in the Health Plan Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2024 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of the Health Plan Medical Policy Coverage Guidelines is with the Health Plan and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Health Plan Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of the Health Plan Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.
CPT is a registered trademark of the American Medical Association.

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Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No Code
HCPCS	J1747
ICD-10 Diagnosis	All related Diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.