Dystrophic Epidermolysis Bullosa
Vyjuvek (beremagene geperpavec-svdt) J3401
Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

- ☐ No skin graft within the past 3 months
- ☐ Documentation confirming mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene
- ☐ Clean cutaneous wound(s) with adequate granulation tissue, vascularization, and uninfected
- ☐ No evidence or history of squamous cell carcinoma in the treatment area
- ☐ Currently receiving supportive wound care

☐ **Continuation Requests: (Clinical documentation required for all requests)**

- ☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

For questions or assistance, please contact Customer Service at 1-877-672-8620, daily, 8am – 8pm (PST) (TTY users should call 1-800-735-2900).

Prior Authorization Group – Dystrophic Epidermolysis Bullosa PA

Drug Name(s):
VYJUVEK **BEREMAGENE GEPERPAVEC-SVDT**

Criteria for approval of Non-Formulary/Preferred Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.
- Continuation Requests: Provider must verify continued clinical benefit in confirmatory trial(s).

Exclusion Criteria:
N/A

Prescriber Restrictions:
Dermatologist or other wound care specialist.

Coverage Duration:
Initial Approval for up to 3 months.
Continuation requests may be approved for up to 3 additional months.

FDA Indications:
Vyjuvek

- Dystrophic epidermolysis bullosa, Wound Care

Off-Label Uses:
N/A

Age Restrictions:

- 6 months or older

Other Clinical Consideration:
N/A

Resources:
https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?navitem=headerLogout#