UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Vyjuvek (beremagene geperpavec-svdt)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(all of the following criteria must be met)*

- ❑ The medication is being prescribed by or in consultation with a dermatologist.
- ❑ The patient is 6 months of age or older.
- ❑ The patient is not pregnant.
- ❑ If the patient is an individual of childbearing potential, the patient is on an effective method of contraception during treatment with Vyjuvek.
- ❑ The patient has a diagnosis of Dystrophic Epidermolysis Bullosa (DEB) with genetically confirmed mutation(s) in the *collagen type VII alpha 1 chain (COL7A1)* gene.
  Chart Note Page #: _____
- ❑ Documented baseline number and size of wounds. Chart Note Page #: _____
- ❑ The patient has at least one open wound meeting all of the following criteria:
  - o No evidence of active infection
  - o No current evidence or history of squamous-cell carcinoma

  Chart Note Page #: _____
- ❑ Vyjuvek will be applied to wounds once weekly by a healthcare professional who has been trained in proper application of Vyjuvek; and arrangements have been made to ensure the patient will be compliant with weekly dosing.
- ❑ The Vyjuvek dose will be determined by the patient's age, wound size & maximum weekly dose threshold per the United States Food and Drug Administration-approved labeling.
  Chart Note Page #: _____

- ❑ Requested dosing: _____

Re-authorization Criteria:

- ❑ Updated letter with medical justification or updated chart notes demonstrating positive clinical response (e.g., complete wound closure and decrease in wound size).
- ❑ Treated wound(s) show no evidence of active infection and no evidence or history of squamous-cell carcinoma.

Initial Authorization: Up to six (6) months, and no more than 26 doses
Re-authorization: Up to six (6) months, and no more than 26 doses

Note:

- ❖ Use HCPCS code for billing
  Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php
- ❖ Diagnosis code: Q81.2 for Dystrophic epidermolysis bullosa

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date