

Vyjuvek® (beremagene geperpavec-svdt) Prior Authorization Form

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Drug Information

Physician billing (HCPCS code: _____) Pharmacy billing (NDC: _____)

Dose: _____ **Regimen:** _____ **Start Date (or date of next dose):** _____

Billing Provider Information

Provider NPI: _____ **Provider Name:** _____

Provider Phone: _____ **Provider Fax:** _____

Prescriber Information

Prescriber NPI: _____ **Prescriber Name:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____ **Specialty:** _____

Criteria

For Initial Authorization: (Initial approvals will be for 3 months)

1. Clinical documentation (i.e., recent office notes) must be submitted with this request documenting the member's treatment plan. Is this information attached? Yes ___ No ___
2. Please indicate the diagnosis and information:
 - Dystrophic Epidermolysis Bullosa (DEB)
 - Other _____
3. Has diagnosis been confirmed by a mutation in the collagen type VII alpha 1 chain (COL7A1) gene? Yes ___ No ___
 - a. If yes, please submit results of genetic testing.
4. Is Vyjuvek® prescribed by, or in consultation with, a dermatologist or other specialist with expertise in the treatment of DEB (or an advanced care practitioner with a supervising physician who is a dermatologist or other specialist with expertise in the treatment of DEB)? Yes ___ No ___
5. Will Vyjuvek® be prepared by a pharmacist trained in the preparation of Vyjuvek® prior to dispensing? Yes ___ No ___
 - a. If yes, please indicate the pharmacy where Vyjuvek® will be prepared: _____
6. Will Vyjuvek® be shipped to the administering location via cold chain supply? Yes ___ No ___
7. Will the pharmacy and administering location adhere to the storage and handling requirements in the Vyjuvek® package labeling? Yes ___ No ___
8. Will Vyjuvek® be administered by a health care professional (HCP) or member/caregiver trained in the administration of Vyjuvek®? Yes ___ No ___
 - a. Please indicate who will administer Vyjuvek® (i.e., caregiver, member, home health nurse): _____
 - b. In what setting (i.e., treatment facility, HCP office, home health, member's home) will Vyjuvek® be administered? _____
 - c. If member or caregiver is administering Vyjuvek®, have they been trained on the dosing, administration, and storage of Vyjuvek®? Yes ___ No ___

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<p><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u></p> <p><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Criteria

For Initial Authorization: (continued)

9. Will Vyjuvek® be dosed per package labeling and applied to the same wound(s) until closed before selecting new wound(s) to treat, and will the provider prioritize weekly treatment to previously treated wounds if they re-open? Yes ___ No ___
10. Has the member or caregiver(s) been counseled on the precautions prior to and during treatment with Vyjuvek® that are listed in the package labeling, including avoiding direct contact with treated wounds and dressings until the next dressing change following administration? Yes ___ No ___
11. If member is female:
- a. Is member pregnant? Yes ___ No ___
 - b. Has member had a negative pregnancy test immediately prior to therapy initiation? Yes ___ No ___
 - c. If member is of reproductive potential, are they willing to use effective contraception while on therapy? Yes ___ No ___
12. Will Vyjuvek® be used concomitantly with Filsuvez® (birch triterpenes 10% topical gel)? Yes ___ No ___
13. Will Vyjuvek® be used on wounds treated with Zevaskyn™ (prademagene zamikeracel)? Yes ___ No ___

Additional Information: _____

For Continued Authorization: (Approvals will be for 1 year)

1. Date of last dose: _____
2. Is the member responding well to treatment with Vyjuvek® as indicated by the presence of wound healing? Yes ___ No ___
3. Does prescriber confirm Vyjuvek® will not be applied to closed wounds? Yes ___ No ___
4. Please submit clinical documentation (i.e., recent office notes) documenting the member's response to treatment and ongoing treatment plan. Is this information attached? Yes ___ No ___
5. Please indicate who will administer Vyjuvek® and in what setting (i.e. treatment facility, HCP office, home health, member's home): _____
6. If member or caregiver is administering Vyjuvek®, have they been trained on the dosing, administration, and storage of Vyjuvek®? Yes ___ No ___

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Prescriber Signature: _____ **Date:** _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.

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