OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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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. Please indicate the diagnosis and information:
   - ☐ Dystrophic Epidermolysis Bullosa (DEB)
   - ☐ Other
2. 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.
3. Is Vyjuvek™ being prescribed by 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☐
4. Will Vyjuvek™ be prepared by a pharmacist trained in the preparation of Vyjuvek™ prior to administration? Yes☐ No☐
   a. If yes, please indicate the pharmacy where Vyjuvek™ will be prepared:
5. Will Vyjuvek™ be shipped to the administering provider via cold chain supply? Yes☐ No☐
6. Will pharmacy and provider adhere to the storage and handling requirements in the Vyjuvek™ package labeling? Yes☐ No☐
7. Will Vyjuvek™ be administered by a health care professional (HCP) trained in the administration of Vyjuvek™? Yes☐ No☐
   a. Please indicate who will administer Vyjuvek™ and their credentials:
   b. In what setting (i.e., treatment facility, HCP office, home health) will Vyjuvek™ be administered?

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	CONFIDENTIALITY NOTICE *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.*

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Page 2 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

For Initial Authorization: *(continued)*

8. 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____
9. 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 for 24 hours following administration? Yes____ No____
10. 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____

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____

Additional Information:

(Page 2 of 2)

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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