

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.)

- Please indicate the diagnosis and information:
 - Dystrophic Epidermolysis Bullosa (DEB)
 - Other _____
- Has diagnosis been confirmed by a mutation in the collagen type VII alpha 1 chain (COL7A1) gene?
Yes ___ No ___
 - If yes, please submit results of genetic testing.
- 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 ___
- Will Vyjuvek™ be prepared by a pharmacist trained in the preparation of Vyjuvek™ prior to administration?
Yes ___ No ___
 - If yes, please indicate the pharmacy where Vyjuvek™ will be prepared: _____
- Will Vyjuvek™ be shipped to the administering provider via cold chain supply? Yes ___ No ___
- Will pharmacy and provider adhere to the storage and handling requirements in the Vyjuvek™ package labeling? Yes ___ No ___
- Will Vyjuvek™ be administered by a health care professional (HCP) trained in the administration of Vyjuvek™? Yes ___ No ___
 - Please indicate who will administer Vyjuvek™ and their credentials: _____
 - In what setting (i.e., treatment facility, HCP office, home health) will Vyjuvek™ be administered?

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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

Criteria

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: _____

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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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