Prior Authorization Criteria

MISSISSIPPI DIVISION OF MEDICAID

VYJUVEK (beremagene geperpavec-svdt) PA Criteria

VYJUVEK is a topical gene therapy indicated for the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) with mutation(s) in the collagen type VII alpha 1 chain (COL7A1).

VYJUVEK is prepared by a pharmacist for administration by a healthcare care provider in a clinic or home setting.

Initial authorization: 6 months

☐ Member is 6 months of age or older **-AND-**

☐ Medication must be prescribed by or in consultation with a dermatologist specializing in EB care **-AND-**

☐ Member has a diagnosis of DEB (either DDEB or RDEB) with documentation of mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Requestor shall include documentation of the genetic laboratory test result with specific mutations.

Qty Limit: 26 vials/6 months

Reauthorization Criteria: 12 months

☐ Member continues to meet initial authorization criteria **-AND-**

☐ Provider documentation of continued benefit as evidenced by improved wound healing defined as complete (100%) wound closure confirmed and documented in chart