

Request for Prior Authorization for Epidermolysis Bullosa (EB) Products
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030

All requests for Epidermolysis bullosa (EB) Products require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Epidermolysis bullosa (EB) products include Vyjuvek (beremagene geperpavec) and Zevaskyn (pradamagene zamikeracel). New products with this classification will require the same documentation.

Prior Authorization Criteria:

For all requests for EB Products, all of the following criteria must be met in addition to the product-specific criteria below:

- Must be prescribed by or in consultation with a dermatologist
- Must have an open wound present for at least 21 days with no evidence or history of squamous-cell carcinoma or active infection
- Must not be used in combination with another EB Product on the same wound
- Must be age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

For Vyjuvek (beremagene geperpavec):

- Must have a diagnosis of Dystrophic Epidermolysis Bullosa (DEB)
- Must have a mutation in the *collagen type VII alpha 1 chain* (COL7A1) gene confirmed by genetic testing
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
 - Must meet all initial criteria and provide documentation of improvement in wound healing (e.g. decrease in wound size for ongoing treatment, wound closure of separate and previously-treated wounds)
- **Reauthorization Duration of Approval:** 12 months

For Zevaskyn (pradamagene zamikeracel) gene-modified cellular sheets:

- Must have a diagnosis of Recessive Dystrophic Epidermolysis Bullosa (BDEB)
- Must have a biallelic mutation in the *collagen type VII alpha 1 chain* (COL7A1) gene confirmed by genetic testing
- Must have positive expression of the non-collagenous region 1 of the type 7 collagen protein (NC1+) in the skin
- Must have a chronic open wound (open for at least 6 months) that has NOT previously been treated with this or another EB therapy (e.g. Filsuvez, Vyjuvek)

Duration of approval: 1 treatment course (per lifetime)



Updated: 09/2025
Approved: 10/2025

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

**EPIDERMOLYSIS BULLOSA (EB) PRODUCTS
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: 1-844-325-6251 Mon – Fri 8 am to 7 pm**

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Directions:	Quantity: Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Billing Information

This medication will be billed: <input type="checkbox"/> at a pharmacy OR <input type="checkbox"/> medically, JCODE:	
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other	

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:
Is there an open wound that has been present for at least 21 days with no evidence or history of squamous-cell carcinoma or active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will this be used in combination with any other EB-specific treatment on the same wound? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For Vyjuvek and Zevaskyn: Has the mutation in the <i>collagen type VII alpha 1 chain (COL7A1)</i> gene confirmed by genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
For Zevaskyn: Is there positive expression of the non-collagenous region 1 of the type 7 collagen protein (NC1+) in the skin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the wound to be treated been open for at least 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the wound(s) to be treated been previously treated with another EB-specific therapy (e.g. Filsuvez, Vyjuvek)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement in wound healing? Yes (please describe or provide chart notes) No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature

Date

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