

POLICY NAME	Vyjuvek (beremagene geperpavec)	POLICY #	3205P
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Criteria

Coverage Criteria

- ☐ Diagnosis of dystrophic epidermolysis bullosa (DEB) confirmed by gene testing
 - Gene testing must be submitted to support pathogenic mutations in COL7A1 gene
- ☐ Documentation to support open skin wounds
 - Application is limited to open skin wounds only
- ☐ Age 6 months or older
- ☐ Prescribed by or in consultation with a dermatologist (skin doctor) who specializes in epidermolysis bullosa management
- ☐ Clinical review of documentation confirming that patient has met all of the above requirements for treatment completed by both a pharmacist and medical director

Exclusion Criteria – Any of the following prevents coverage

- ☐ History of squamous cell carcinoma or actively receiving cancer treatment
- ☐ History of skin graft within previous 3 months