

POLICY NAME

Vyjuvek (beremagene geperpavec)

POLICY #

Criteria

Exclusion Criteria – Any of the following prevents coverage

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

Coverage Criteria

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