Field Name	Field Description
Prior Authorization Group Description	Epidermolysis Bullosa Agents
Drugs	Vyjuvek (beremagene geperpavec-svdt), Filsuvez (birch triterpenes)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	• Other forms of epidermolysis bullosa, such as epidermolysis bullosa simplex, junctional epidermolysis bullosa, kindler epidermolysis bullosa
Required Medical Information	See "Other Criteria"
Age Restrictions	Per prescribing information
Prescriber Restrictions	Prescriber must be a dermatologist, geneticist, or specialist experienced in the treatment of dystrophic epidermolysis bullosa.
Coverage Duration	If all of the criteria are met, the initial request will be approved for three (3) months. Subsequent requests will be approved for six (6) months.
Other Criteria Revision/Review Date: 4/2025	**Initial Authorization:** • Patient has a diagnosis of dystrophic or junctional epidermolysis bullosa, with confirmed mutation(s) e via genetic testing. • Requested product is FDA approved for the patient's epidermolysis bullosa subtype • Documentation is provided that wound(s) to be treated are clean with adequate granulation tissue, excellent vascularization, and do not appear infected • Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated • Medication is prescribed at an FDA approved dose, and maximum weekly dispensable amount is not exceeded o Vyjuvek: Requests exceeding more than one vial per week will not be approved. o Filsuvez: documentation of size of treatment area(s) and frequency of dressing changes is required. One tube of Filsuvez covers up to 250 cm2 surface area. Requests exceeding a quantity sufficient to cover the treatment area more than once daily will not be approved. **Re-Authorization:** • Documentation or provider attestation of positive clinical response (i.e. improvement in wound appearance, wound closure, healing, etc.) • Documentation indicating need for continued treatment is needed (either to partially healed wounds or to other wound sites)

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	• Documentation is provided that there is no evidence of, or history of squamous cell carcinoma in the wound(s) to be treated
	• Medication is prescribed at an FDA approved dose, and maximum weekly dispensing amount is not exceeded.
	  o Vyjuvek: Requests exceeding more than one vial per week will not be approved.
	  o Filsuvez: documentation of size of treatment area(s) and frequency of dressing changes is required. One tube of Filsuvez covers up to 250 cm2 surface area. Requests exceeding a quantity sufficient to cover the treatment area more than once daily will not be approved.
	
	If all of the above criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.