GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
VYJUVEK PA SUMMARY

Preferred	Non-Preferred
n/a	Vyjuvek (beremagene geperpavec-svdt)

LENGTH OF AUTHORIZATION: 6 months

NOTE: The criteria details below are for the outpatient pharmacy program. If a medication is being administered in a physician's office or clinic, the medication must be billed through the physician services program and not the outpatient pharmacy program. Information regarding the DCH physician services program is located at www.mmis.georgia.gov.

PA CRITERIA:

Vyjuvek

- Approvable for members 6 months of age or older with a diagnosis of dystrophic epidermolysis bullosa (DEB) confirmed with mutation(s) in the *collagen type VII alpha 1 chain (COL7A1)* gene ***AND***
- Member has at least one recurrent or chronic open wound that meets all of the following criteria:
  - Adequate granulation tissue,
  - Excellent vascularization,
  - No evidence of active wound infection ***AND***
  - No evidence or history of squamous cell carcinoma.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services and select that manual.