



**GEORGIA MEDICAID FEE-FOR-SERVICE
WOUND CARE PRODUCTS PA SUMMARY**

Preferred	Non-Preferred
Filsuvez (birch triterpenes)	Vyjuvek (beremagene geperpavec-svdt)

LENGTH OF AUTHORIZATION: Varies

NOTES:

- ❖ **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.
- ❖ Medication must be prescribed by or in consultation with a dermatologist with expertise in the treatment of epidermolysis bullosa (EB).

PA CRITERIA:

Filsuvez

- ❖ 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 when standard wound care management not been adequate in healing wounds (e.g., daily wound dressings, pain management, controlling infections).
- ❖ Approvable for members 6 months of age or older with a diagnosis of junctional epidermolysis bullosa (JEB) confirmed with mutation(s) in at least one of the following genes: LAMA3, LAMB3, LAMC2, COL17A1, ITGA6, ITGB4 or ITGA3 when standard wound care management not been adequate in healing wounds (e.g., daily wound dressings, pain management, controlling infections).
- ❖ In addition, member must have 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 basal or squamous cell carcinoma.

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 when standard wound care management not been adequate in healing wounds (e.g., daily wound dressings, pain management, controlling infections) **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 basal or 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.