UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Zevaskyn (prademagene zamikeracel cellular sheet)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Is the patient 6 years of age or older? ❑ **Yes** ❑ **No**
2. Does the patient have a diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) confirmed by genetic testing? ❑ **Yes** ❑ **No**
   - ☐ Biallelic pathogenic mutations in the COL7A1 gene
   - ☐ Positive expression of the non-collagenous region 1 of the 7 collagen protein (NC1+)
3. Is the medication being prescribed by a dermatologist specializing in the treatment of recessive dystrophic epidermolysis bullosa? ❑ **Yes** ❑ **No**
4. Does the patient have at least one chronic wound of size ≥20 cm^2 (open for ≥6 months) associated with RDEB? ❑ **Yes** ❑ **No**
5. Does the provider confirm that the patient does not have current or history of squamous cell carcinoma at the treatment site? ❑ **Yes** ❑ **No**
6. Does the provider attest that the patient has **NOT** been previously treated with Zevaskyn? ❑ **Yes** ❑ **No**
7. Has the patient tried and failed **BOTH** Vyjuvek (beremagene geperpavec-svdt) and Filsuvez (birch triterpenes) for at least 6 months for each treatment? ❑ **Yes** ❑ **No**
   - ☐ Vyjuvek. Details of failure: _____
   - ☐ Filsuvez. Details of failure: _____

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Initial Authorization: One time treatment - up to 12 sheets can be authorized

Note:

- Provider shall review and submit additional Ultra High Cost Drug Forms below at: https://medicaid.utah.gov/pharmacy/resource-library/
  - UHCD Written Claim of Business Confidentiality Form
  - Ultra High Cost Drug Invoice Submission Form

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date