Reference number(s)
C26814-A

CAREFIRST: VYJUVEK

Client Requested: The intent of the criteria is to ensure that patients follow selection elements as established by CareFirst.

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

FDA-Approved Indication
Vyjuvek is indicated for the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene.

All other indications are considered experimental/investigational and not medically necessary.

I. PRESCRIBER SPECIALTIES

This medication must be prescribed by or in consultation with a dermatologist or wound care specialist.

II. CRITERIA FOR INITIAL APPROVAL

Dystrophic Epidermolysis Bullosa (DEB)
Authorization of 6 months may be granted for treatment of wounds in members with dystrophic epidermolysis bullosa (DEB) when all of the following criteria are met:

A. Member is 6 months of age and older.
B. Member has clinical manifestations of disease (e.g., extensive skin blistering, skin erosions, scarring).
C. Member has genetic test results confirming a mutation in the COL7A1 gene.
D. Member does not have a history of squamous cell carcinoma in the affected wound(s) that will receive treatment.
E. Vyjuvek will be administered once weekly to the affected wound(s) by a healthcare professional either at a healthcare professional setting (e.g., clinic) or a home setting.
F. Vyjuvek will not be administered to wound(s) that are currently healed.

III. CRITERIA FOR REAUTHORIZATION

Dystrophic Epidermolysis Bullosa (DEB)
Reauthorization of 6 months may be granted upon receipt of documentation indicating clinical response to therapy.

DOCUMENT HISTORY
Created: Specialty Clinical Development (JS) 11/2023
Revised: AN 12/2023
Reviewed: CDPR