Zevaskyn

CareFirst Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: ______________________________ **Date**: _________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** ________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** _______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: __________________________*kg*

Patient Height: __________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

What is the ICD-10 code? _____________

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Zevaskyn C29975-A – 05/2026.

Criteria Questions:

1. What is the diagnosis?
❒ Recessive dystrophic epidermolysis bullosa (RDEB), *Continue to #2*
❒ Other, please specify: _________________________, *Continue to #2*

2. Is this request for continuation of therapy?
❒ Yes, *Continue to #10*
❒ No, *Continue to #20*

Recessive dystrophic epidermolysis bullosa (RDEB)
Continuation

10. Is there documentation indicating that retreatment is needed for a previously treated wound? ***ACTION REQUIRED****: If Yes, please attach documentation indicating that retreatment is needed for a previously treated wound*
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Initiation

20. Has the diagnosis been confirmed by genetic test results documenting biallelic pathogenic mutations in the COL7A1 gene? ***ACTION REQUIRED****: If Yes, please attach genetic test results confirming biallelic pathogenic mutations in the COL7A1 gene*
❒ Yes, *Continue to #21*
❒ No, *Continue to #21*

21. Does the patient have clinical manifestations of disease (e.g., extensive skin blistering, skin erosions, scarring)? ***ACTION REQUIRED****: If Yes, please attach medical records documenting clinical manifestations of disease*
❒ Yes, *Continue to #22*
❒ No, *Continue to #22*

22. Does the patient have cutaneous wound(s) which are adequate for treatment (e.g., Stage 2 wounds that have an area greater than or equal to 20 cm2) and have been present for at least 3 months?
❒ Yes, *Continue to #23*
❒ No, *Continue to #23*

23. Does the patient have positive expression of the non-collagenous region 1 of the type 7 collagen protein (NC1+) in the skin? ***ACTION REQUIRED****: If Yes, please attach test results documenting positive expression of the non-collagenous region 1 of the type 7 collagen protein (NC1+) in the skin*
❒ Yes, *Continue to #24*
❒ No, *Continue to #24*

24. Does the patient have current evidence of squamous cell carcinoma in the affected wound(s) that will receive treatment?
❒ Yes, *Continue to #25*
❒ No, *Continue to #25*

25. Does the patient have an active infection?
❒ Yes, *Continue to #26*
❒ No, *Continue to #26*

26. Will the requested medication be administered to wound(s) that are currently healed?
❐ Yes, *Continue to #27*
❐ No, *Continue to #27*

27. Will the patient use Vyjuvek (beremagene geperpavec-svdt) or Filsuvez (birch triterpenes) on wound(s) that have been previously treated with the requested medication?
❐ Yes, *Continue to #28*
❐ No, *Continue to #28*

28. Is the requested medication prescribed by or in consultation with a dermatologist or wound care specialist?
❐ Yes, *No Further Questions*
❐ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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