AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

VYJUVEK

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

Physician Administered Drug: This form is only to be used for members obtaining the medication from a pharmacy through billing the pharmacy benefit at point-of-sale. Please refer to Appendix B: Physician Administered Drug Criteria for members/providers who will obtain the medication through the medical benefit.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

For initial approval, complete the following questions to receive a 6-month approval:

1. Does the member have a diagnosis of dystrophic epidermolysis bullosa (DEB) as established by detection of mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene on molecular genetic testing? **AND**

   ☐ Yes ☐ No

2. Does the prescriber attest that the member has not received a skin graft in the area to be treated within the prior 3 months? **AND**

   ☐ Yes ☐ No

3. Does the prescriber attest that Vyjuvek will not be used concurrently in the same wound with another disease-modifying therapeutic agent indicated for DEB (e.g., birch triterpenes, etc.) (NOTE: this does not include disease/wound management incidentals like topicals, dressings, antibiotics, etc.)? **AND**

   ☐ Yes ☐ No

4. Will Vyjuvek be used on cutaneous wound(s) which are clean with adequate granulation tissue, excellent vascularization, and do not appear infected?

   ☐ Yes ☐ No

For renewal, complete the following questions to receive a 6-month approval:

1. Does the member continue to meet the above criteria? **AND**

   ☐ Yes ☐ No

2. Does the member have absence of unacceptable toxicity from the drug? **AND**

   ☐ Yes ☐ No

3. Does the member have disease response with treatment as defined by improvement (healing) of treated wound sites, and/or reduction in skin infections, etc., as attested by the treating physician? **AND**

   ☐ Yes ☐ No

4. Does the member require continued treatment due to new or existing open wounds?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.