PRIOR AUTHORIZATION REQUEST

Filsuvez

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** prior authorization requests.

1	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
2	Has the patient been receiving medication samples of Filsuvez? [If yes, skip to question 8.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for Filsuvez? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
5	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	What is the indication or diagnosis? [] Dystrophic epidermolysis bullosa (If checked, go to 7) [] Junctional epidermolysis bullosa (If checked, go to 7) [] Other (If checked, no further questions)		
7	Is the requested medication prescribed by or in consultation with a dermatologist or wound care specialist? [No further questions.]	Yes	No
8	Is the patient at least 6 months of age and older? [If no, no further questions.]	Yes	No
9	What is the indication or diagnosis? [] Dystrophic epidermolysis bullosa (If checked, go to 10) [] Junctional epidermolysis bullosa (If checked, go to 11) [] Other (If checked, no further questions)		
10	Has the patient had a trial and failure (for at least 90 days), contraindication to, or intolerance to Vyjuvek (beremagene geperpavec-svdt)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Does the patient have a documented diagnosis of dystrophic epidermolysis bullosa or junctional epidermolysis bullosa confirmed by genetic testing? [If no, no further questions.]	Yes	No
12	Is the target wound(s) 10 cm2 to 50 cm2? [If no, no further questions.]	Yes	No
13	Is the target wound(s) greater than or equal to 21 days and less than 9 months old? [If no, no further questions.]	Yes	No
14	Does the target wound(s) appear to be infected?	Yes	No

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	[If yes, no further questions.]		
15	Has squamous cell and/or basal cell carcinoma been ruled out for the target wound(s)? [If no, no further questions.]	Yes	No
16	Is the requested medication prescribed by or in consultation with a dermatologist or wound care specialist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

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