

New Hampshire Medicaid Fee-for-Service Program

Prior Authorization Drug Approval Form

Epidermolysis Bullosa

DATE OF MEDICATION REQUEST:	/ /		
SECTION I: PATIENT INFORMATION AND MEDICATION	N REQUESTED		
LAST NAME:	FIRST NAME:		
MEDICAID ID NUMBER:	DATE OF BIRTH:		
GENDER: Male Female Drug Name:	Strength:		
Dosing Directions:	Length of Therapy:		
SECTION II: PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
SPECIALTY:	NPI NUMBER:		
PHONE NUMBER:	FAX NUMBER:		

SECTION III: CLINICAL HISTORY

1. Is the prescriber a dermatologist or a geneticist, or has one been consulted?

2. Filsuvez: Has the patient been diagnosed with dystrophic or epidermolysis bullosa? Provide confirmation with one of the following:

- Immunofluorescence mapping (IFM) •
- Transmission electron microscopy (TEM) •
- Genetic testing •
- 3. Filsuvez: Does the patient have current evidence or history of squamous cell carcinoma in the Yes | No area where treatment will be applied?

(Form continues on next page.)



Yes

Yes

No

No

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		DATE OF MEDICATION REQUEST:	/ /	
PA	ATIENT LA	ST NAME:	PATIENT FIRST NAME:	
4.	Filsuvez	Does the patient have an active infection in	the area where treatment will be applied?	Yes No
5.	Vyjuvek	: Has the patient had a skin graft within the I	past 3 months?	Yes No
	a. If y	es, list date of graft:		
6.		: Does the patient have a diagnosis of dystro A7A1 gene?	phic epidermolysis bullosa with a mutation in	n 🗌 Yes 🗌 No
	a. If y	es, provide testing results:		_
7.	7. Vyjuvek: Is the cutaneous wound clean with adequate granulation tissue, excellent Yes Yes vascularization, and absent of infection?			Yes No
8.		any additional information that would help i please use another page.	n the decision-making process? If additional	space is

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE:		DATE:
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