Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Epidermolysis Bullosa

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION 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? ☐ Yes ☐ No
2. **Filsuvez:** Has the patient been diagnosed with dystrophic or epidermolysis bullosa? Provide confirmation with one of the following: ☐ Yes ☐ No
   - 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 area where treatment will be applied? ☐ Yes ☐ No

(Form continues on next page.)

Review Date: 11/01/2025

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PATIENT LAST 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 past 3 months? ☐ Yes ☐ No
   a. If yes, list date of graft: _____
6. **Vyjuvek:** Does the patient have a diagnosis of dystrophic epidermolysis bullosa with a mutation in the COLA7A1 gene? ☐ Yes ☐ No
   a. If yes, provide testing results: _____
7. **Vyjuvek:** Is the cutaneous wound clean with adequate granulation tissue, excellent vascularization, and absent of infection? ☐ Yes ☐ No
8. **Zevaskyn**: Has the patient been diagnosed with recessive dystrophic epidermolysis bullosa? ☐ Yes ☐ No
   a. Was this confirmed by genetic testing to show biallelic mutation(s) on the collagen type VII alpha 1 chain gene?
   b. Has it been confirmed that both parents do not have evidence of dominant disease?
9. **Zevaskyn:** Are the cutaneous wounds at least stage 2 with an area of at least 20 cm^2 and present for at least 6 months? ☐ Yes ☐ No
10. **Zevaskyn**: Does the patient have severe hypersensitivity to vancomycin or amikacin? ☐ Yes ☐ No
11. **Zevaskyn:** Does the patient have current evidence or history of squamous cell carcinoma in the area where treatment will be applied? ☐ Yes ☐ No
12. **Zevaskyn**: Will Zevaskyn be used in concurrently with Filsuvez or Vyjuvek on the same wound? ☐ Yes ☐ No
13. **Zevaksyn**: Females of childbearing potential have been educated on effective contraception to prevent pregnancy during treatment? ☐ Yes ☐ No
14. Is there any additional information that would help in the decision-making process? **If additional space is needed, please use another page.**

Phone: 1-866-675-7755
Fax: 1-888-603-7696

Prime THERAPEUTICS™

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SECTION IV: RENEWAL

1. Does the patient continue to meet the drug-specific criteria above? ☐ Yes ☐ No
2. Has the patient demonstrated clinical benefit with use? ☐ Yes ☐ No
3. Has the patient experienced any treatment-restricting adverse effect? ☐ Yes ☐ No
4. **ZEVASKYN only:** Is additional treatment required for new wounds or the expansion of pre-existing wounds? ☐ Yes ☐ No

Fax to Prime Therapeutics Management LLC if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-314-8101

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**:_____