



State of Oklahoma
SoonerCare

Zevaskyn™ (prademagene zamikeracel) Prior Authorization Form

Member Name: _____ Date of Birth: _____ Member ID#: _____

Drug Information

Physician billing (HCPCS code: _____) Start Date: _____

Billing Provider Information

Provider NPI: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Prescriber Information

Prescriber NPI: _____ Prescriber Name: _____

Prescriber Phone: _____ Prescriber Fax: _____ Specialty: _____

Criteria

For Authorization: (Approvals will be for 1 year for 1 treatment cycle)

1. Clinical documentation (i.e., recent office notes) must be submitted with the request documenting the member's treatment plan. Is this information attached? Yes ___ No ___

2. Please indicate the diagnosis and information

Recessive Dystrophic Epidermolysis Bullous (RDEB)

- a. Will Zevaskyn™ be used for the treatment of wounds associated with RDEB? Yes ___ No ___
- b. Was diagnosis confirmed by biallelic pathogenic variants in the collagen type VII alpha 1 chain (COL7A1) gene? Yes ___ No ___ (results of genetic testing must be submitted with request)
- c. Is Zevaskyn™ prescribed by a dermatologist at a qualified treatment center with expertise in the treatment of RDEB? Yes ___ No ___
- d. Has member been counseled and will not use other epidermolysis bullous products (e.g., Vyjuvek®, Filsuvez®) on wounds treated with Zevaskyn™? Yes ___ No ___
- e. Will Zevaskyn™ be administered at a Zevaskyn™ qualified treatment center? Yes ___ No ___
Name of facility: _____
- f. Does the receiving facility have a mechanism in place to track the patient-specific Zevaskyn™ from receipt to storage to administration? Yes ___ No ___

Other: _____

Additional Information: _____

Prescriber Signature: _____ Date: _____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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