



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 PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

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	Yes	No

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

Version 02.2026

PRIOR AUTHORIZATION REQUEST

requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If no, skip to question 8.]

- | | | | |
|----|---|-----|----|
| 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?
<input type="checkbox"/> Dystrophic epidermolysis bullosa (If checked, go to 7)

<input type="checkbox"/> Junctional epidermolysis bullosa (If checked, go to 7)

<input type="checkbox"/> 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?
<input type="checkbox"/> Dystrophic epidermolysis bullosa (If checked, go to 10)

<input type="checkbox"/> Junctional epidermolysis bullosa (If checked, go to 11)

<input type="checkbox"/> 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 cm ² to 50 cm ² ?
[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 |

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Version 02.2026



PRIOR AUTHORIZATION REQUEST

14	Does the target wound(s) appear to be infected? [If yes, no further questions.]	Yes	No
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 authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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Version 02.2026