Vyjuvek® (beremagene geperpavec-svdt)

Effective Date: 7/1/2024
Medical Care Management Committee Approval: 04/25/2024

Contents

Coverage Policy

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures, medications and therapy. This Guideline does not address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

This policy applies to the following Vyjuvek® (beremagene geperpavec-svdt):

HCPCS Code	Description
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 PFU/ml vector genomes, per 0.1 ml

Initial Coverage Criteria

Vyjuvek® (beremagene geperpavec-svdt) will be considered medically necessary for members meeting ALL of the following criteria:

1. Prescribed by or in consultation with a dermatologist; AND
2. Member is greater than or equal to 6 months of age; AND
3. Member has a diagnosis of dystrophic epidermolysis bullosa (DEB) confirmed by genetic test showing mutation in the collagen type VII alpha 1 chain (COL7A1) gene; AND
4. Provider attestation that member has at least one recurrent or chronic cutaneous wound that has adequate granulation tissue, excellent vascularization and no evidence of infection

Criteria for Continuation of Coverage

1. Member meets initial coverage criteria; AND
2. Documentation of clinical benefit in treated site(s)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive.

HCPCS Code	Description
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10^9 PFU/ml vector genomes, per 0.1 ml

Diagnosis Code	Description
Q81.2	Epidermolysis bullosa

Policy Revision History

Status	Effective Date	Description
Baseline	7/1/2024	Initial version of Vyjuvek Review Guideline