



MEMORANDUM

TO: Valued STAR and CHIP Providers

FROM: El Paso Health

DATE: 12/14/2023

RE: Coverage of Vyjuvek Begins Jan. 2024; Prior Authorization Effective Feb. 2024

On Jan. 1, 2024, Vyjuvek will become a benefit of Medicaid and CHIP. HHSC will require prior authorization for Vyjuvek (procedure code J3401) for Medicaid and CHIP, effective Feb. 1, 2024.

1. Prior authorization is required for Vyjuvek (beremagene geperpavec-svdt)
2. Initial therapy for Vyjuvek may be approved for a 6-month duration if all the following criteria are met:
 - a. Client is at least 6 months or older.
 - b. Client has a confirmed diagnosis of dystrophic epidermolysis bullosa (DEB) (diagnosis code Q81.2).
 - c. Genetic test confirming client has a mutation in the collagen type VII alpha 1 chain (COL7A1) gene.
 - d. Client does not have current evidence or history of squamous cell carcinoma or active infection in the area requiring Vyjuvek application.
 - e. Client (female of childbearing age) has a confirmed negative pregnancy status as treatment with Vyjuvek may be potentially hazardous to a fetus.
3. For renewal or continuation therapy client must meet the following requirements:
 - a. Client met initial requirements to prior authorization and is currently treated with Vyjuvek with no severe adverse reactions.
 - b. Client experienced positive clinical response to therapy as documented by any of the following:



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i. Reduction in the number of wounds, decrease in wound size, increase in granulation tissue, and/or complete wound closure.

c. Client has not experienced any complications while being treated with Vyjuvek.

Refer to the **Outpatient Drug Services Handbook** of the Texas Medicaid Provider Procedure Manual for more details on the clinical policy and prior authorization requirements. [Texas Medicaid Provider Procedures Manual | TMHP](#)

If you have any questions regarding this communication please contact our Provider Relations team at 915-532-3778 or email us at ProviderRelationsDG@elpasohealth.com