ambetter. FROM peach state health plan

Telephone: (800) 514-0083 option 2
Fax: (866) 374-1579

Prademagene Zamikeracel (Zevaskyn)
PDAC Drug Review Form

The information below can be completed by the Health Plan and/or Centene Pharmacy Services (CPS) staff

Patient Information

*Last Name:	*First Name:	Middle:	*DOB: / /
Daytime Phone:	Evening Phone:	*Sex: ☐ Male ☐ Female	

Insurance Information

*Primary Insurance (Health Plan Name and State)	*ID #:

Physician Information

*Name:	*Specialty:	*Phone #:

Procedural Hospital

*Hospital Name:

Primary Diagnosis

*ICD-10 Code: _____

☐Recessive Dystrophic Epidermolysis Bullosa (RDEB) ☐Other: _____

Prescription Information

MEDICATION	STRENGTH	*DIRECTIONS	QUANTITY	REFILLS
Zevaskyn (Prademagene Zamikeracel)				

Clinical Information

***** *Please submit supporting clinical documentation* *****

* **THERAPY Start Date**: _____

1. Is therapy prescribed by or in consultation with a geneticist, dermatologist, or histopathologist ? ☐Yes ☐No
2. Is RDEB evidenced by two copies of positive collagen type VII alpha 1 chain (COL7A1) gene mutation by one of the following skin biopsy genetic testing?
   ☐Yes **Mark all that apply** ☐No
   ☐Positive immunofluorescence ☐Transmission electron microscopy ☐Antigenic mapping
   ☐Other: _____
3. Does provider attest patient is concomitantly receiving standard-of-care preventive or treatment therapies for wound care (e.g., polymeric membrane, super-absorbent dressings, soft-silicone foam, enzyme alginogel)?
   ☐Yes **Please specify and describe wound care below** ☐No

   _____

   _____
4. Do any of the following apply to the wound site? ☐Yes ☐No
   ☐Chronic and open (e.g., stage 2 chronic wound) ☐Area of at least 20 cm^2
   ☐Present for at least 6 months ☐Have not previously been treated with Zevaskyn
5. Does patient have current evidence or history of squamous cell carcinoma in the area that will undergo treatment?
   ☐Yes ☐No
6. Is Zevaskyn prescribed concurrently with Vyjuvek or Filsuvez? ☐Yes ☐No

Complete this section ONLY for indications <u>other</u> than RDEB:

7. Has patient tried and failed, or is contraindicated to, accepted standards of care? ☐Yes ☐No
   If yes, submit documentation and answer the following:
   a. Please list all previous therapies: _____
   b. Was patient adherent to previously tried therapies? ☐Yes ☐No ☐No, patient intolerant to drug

Information

*Number:	*Date of Request:

PDAC updated: 09/08/2025
AMB25-GA-HP-00216

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*HCPCS Code:	*Decision Due Date:

Please continue to page 2.

Patient Name: _____ **DOB:** _____

* Line of Business:	* Benefit:
☐ Commercial ☐ Health Insurance Marketplace ☐ Medicaid ☐ Medicare	☐ Medical ☐ Pharmacy

*** Choose one criteria option below based on line of business:**

Medicare Criteria Only:

☐ Medicare Local Coverage Decision (LCD) specific for your region
Please include policy of link to LCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

☐ Medicare National Coverage Decision (NCD).
Please include policy of link to NCD, followed by any applicable Medicare Part B step therapy requirements in MCPB.ST.00.

Medicaid, Commercial, Exchange (Ambetter) Criteria:

☐ Centene Policy [**CP.PHAR.609 Prademagene Zamikeracel (Zevaskyn)**]
Date Policy last reviewed/approved by plan (we want to be sure we are using the version approved by your plan):

_____

OR

☐ State or Health Plan Specific (please include policy)