

Medical Policy:
Zevaskyn



Last review date: 05/21/2025

Applicable Products:
Zevaskyn (prademagene zamikeracel)

Initial Approval Criteria:

Coverage may be approved if all the following are met:

- Patient has a diagnosis of recessive dystrophic epidermolysis bullosa (RDEB); **AND**
- Must be prescribed by or in consultation with a dermatologist; **AND**
- Zevaskyn will be surgically applied at a Qualified Treatment Center (QTC).

Renewal Criteria:

None

Length of Authorization:

1 year

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical or other circumstances may warrant individual consideration, based on review of applicable medical records, as well as other regulatory, contractual and/or legal requirements.

Medical policies do not constitute medical advice, nor are they intended to govern the practice of medicine. They are intended to reflect reimbursement and coverage guidelines. Coverage for services may vary for individual members, based on the terms of the benefit contract.