prademagene zamikeracel (Zevaskyn™)

Medicare Advantage Medical Policy #MA-232
Original Effective Date: 10/01/2026
Current Effective Date: 10/01/2026

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Blue Advantage does not cover investigational or experimental services, including any drug, device, procedure, or service provided under the investigational arm of a clinical trial or study unless mandated by the Centers for Medicare and Medicaid Services. Coverage is limited to routine services for Category A IDE studies and to devices and related services for Category B IDE studies when not supplied by the trial sponsor. Approved IDE studies are posted on www.cms.gov/medicare/coverage/evidence.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider prademagene zamikeracel (Zevaskyn™)‡ for the treatment of recessive dystrophic epidermolysis bullosa to be **eligible for coverage.****

Patient Selection Criteria

Coverage eligibility for prademagene zamikeracel (Zevaskyn) will be considered when the following criteria are met:

- Patient has a diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) with genetic testing confirming pathogenic mutations in both copies of the collagen type VII alpha 1 chain (*COL7A1)* gene; AND
- Patient is greater than or equal to 6 years of age; AND
- Patient has partial-thickness RDEB wounds that have been open chronically for greater than or equal to 6 months; AND
- Patient does NOT have current evidence or history of squamous cell carcinoma in the area that will undergo treatment; AND
- Zevaskyn will not be used in combination with beremagene geperpavec-svdt (Vyjuvek™)‡ or birch triterpenes topical gel (Filsuvez®)‡ (i.e. Vyjuvek or Filsuvez will not be used on wounds that have been treated with Zevaskyn); AND
- Wounds previously treated with Zevaskyn will not be re-treated.

(Note: If all criterion is met, a 90-day approval will be granted.)

When Services Are Considered Not Medically Necessary

Based on review of available data, the Health Plan considers the use of prademagene zamikeracel (Zevaskyn) in patients younger than 6 years of age, those without partial-thickness RDEB wounds that have been open chronically for at least 6 months, wounds with current or a history of squamous cell carcinoma, and wounds previously treated with Zevaskyn to be **not medically necessary.****

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Health Plan considers the use of prademagene zamikeracel (Zevaskyn) when the patient selection criteria are not met (except those noted above to be **not medically necessary****) to be **investigational.***

Background/Overview

Zevaskyn is a topically applied autologous cell-based gene therapy indicated for the treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB). It is manufactured from the patient's own stem cells which are genetically modified to produce type VII collagen. These gene-corrected cells are applied topically to wound areas in a single surgical session. Up to 12 credit card-sized sheets can be applied per procedure—either combined to cover large areas or applied across multiple smaller lesions. The recommended dose of Zevaskyn is based on the surface area of the wound(s). One sheet of Zevaskyn covers an area of 41.25 cm^2. All patients require a 5-10 day inpatient stay post-application to ensure that treated wounds are left undisturbed.

DEB is a rare skin condition that can be inherited in a dominant (DDEB) or recessive (RDEB) pattern, with RDEB typically being more severe. Both subtypes are caused by mutations in the *COL7A1* gene leading to reduced or absent production of the protein COL7, a crucial component of anchoring fibrils which attach the epidermis to the dermis. This deficiency leads to extreme skin fragility that varies in severity depending on if the mutation predisposes to mild or severe disease and whether the patient has completely absent or reduced COL7. The hallmark symptom of DEB is scarring of blisters, both on the skin and on other mucosal surfaces. Secondary extracutaneous complications are common in more severe forms of RDEB. Pain and itching can be constant and also reduce quality of life. Skin and oral mucosal scarring or nail loss can be irreversible and progressive, becoming more pronounced with age. RDEB forms are usually more generalized and characterized by scarring, leading to progressive fusion of fingers and toes resulting in mitten deformities and joint contracture, as well as by major involvement of the mucous membranes (oral cavity and esophagus). Anemia, reduced bone mineral density, renal impairment, and the development of squamous cell carcinoma are also potential complications of severe RDEB. However, there is variability. Early onset and aggressive squamous cell carcinoma at chronic wound sites is typical of RDEB; aggressive squamous-cell cancer is the leading cause of death in patients with DEB.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Zevaskyn was approved in April 2025 for the treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB).

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

The efficacy of Zevaskyn was evaluated in a multi-center, randomized, intrapatient-controlled study. The study compared the application of Zevaskyn to the standard of care treatment in patients with wounds associated with recessive dystrophic epidermolysis bullosa (RDEB). For enrollment, the patients were required to have at least one pair of matched, large (at least one wound $\geq$ 20 cm^2 for treatment and one wound $\geq$ 20 cm^2 for control) and chronic wounds (open for $\geq$ 6 months) associated with RDEB. Patients with current or history of squamous cell carcinoma (SCC) at the treatment site were excluded. Matched wound pairs were randomized in a 1:1 ratio to receive either Zevaskyn (up to 6 sheets) or control treatment (standard of care wound dressings).

A total of 86 wounds in 11 patients were enrolled and treated with Zevaskyn or standard of care in the study. Included patients were aged 6 to 40 years (mean age 23 years). The co-primary efficacy outcome measures were 1) proportion of randomized wound pairs with at least 50% healing at month 6 with confirmation of wound healing two weeks later as assessed using baseline digital photography by the Investigator, and 2) pain reduction as assessed by the mean differences in patient-reported pain scores between randomized wound pairs at Month 6. In the Zevaskyn group, 81% (35 wounds) met the endpoint of 50% healing at month 6 compared to 16% (7 wounds) in the control group ($p < 0.0001$). The mean pain reduction from baseline at month 6 was -3.07 in the Zevaskyn group and -0.90 in the control group ($p = 0.0002$).

References

1. Zevaskyn [package insert]. Abeona Therapeutics, Inc. Cleveland, OH. Updated March 2026.
2. Zevaskyn New Drug Review. IPD Analytics. Updated June 2025.

Policy History

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07/21/2026 UM Committee review and approval. New policy.

Coding

The five character codes included in the Health Plan Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of the Health Plan Medical Policy Coverage Guidelines is with the Health Plan and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the Health Plan Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of the Health Plan Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	No codes
HCPCS	J3389
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or

diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:

1. Consultation with technology evaluation center(s);
2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
3. Reference to federal regulations.

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: All codes listed on the Medical Policy require prior authorization. This ensures appropriate utilization and alignment with current clinical guidelines.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Blue Advantage), Blue Advantage may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Blue Advantage health plan.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.