UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1452-1
Program	Prior Authorization/Notification
Medication	Agamree® (vamorolone)
P&T Approval Date	7/2024
Effective Date	10/1/2024

1. Background:

Agamree (vamorolone) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Agamree** will be approved based on the following criterion:

   a. Diagnosis of Duchenne muscular dystrophy

   Authorization will be issued for 12 months

B. Reauthorization

1. **Agamree** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Agamree therapy

   Authorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity and/or Step Therapy may be in place.

4. References:

1. Agamree [package insert]. Coral Gables, FL: Catalyst Pharmaceuticals, Inc.; March 2024.

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Change Control	
7/2024	New program.