UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1452-2
Program	Prior Authorization/Notification
Medication	Agamree® (vamorolone)*
P&T Approval Date	10/2024
Effective Date	1/1/2025

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.

*Agamree is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

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.; June 2024.

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Change Control	
7/2024	New program.
10/2024	Added exclusion footnote and updated reference.