



UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1452-3
Program	Prior Authorization/Notification
Medication	Agamree® (vamorolone)*
P&T Approval Date	7/2024, 10/2024, 10/2025
Effective Date	1/17/2026

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:

<p>A. <u>Initial Authorization</u></p> <p>1. Agamree* will be approved based on the following criterion:</p> <p>a. Diagnosis of Duchenne muscular dystrophy</p> <p>Authorization will be issued for 12 months</p> <p>B. <u>Reauthorization</u></p> <p>1. Agamree* will be approved based on the following criterion:</p> <p>a. Documentation of positive clinical response to Agamree therapy</p> <p>Authorization will be issued for 12 months</p> <p>^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.</p>
--

*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.



Program	Prior Authorization/Notification - Agamree (vamorolone)
Change Control	
7/2024	New program.
10/2024	Added exclusion footnote and updated reference.
10/2025	Annual review with no changes.