PRIOR AUTHORIZATION REQUEST
Emflaza

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. What is the diagnosis or indication?
   - ☐ Duchenne Muscular Dystrophy (DMD)
   - ☐ All other diagnoses or indications – Please specify _____
2. ☐ Yes ☐ No Is Emflaza being prescribed by or in consultation with a physician who specializes in the treatment of DMD and/or neuromuscular disorders?
3. ☐ Yes ☐ No Is documentation being provided to confirm that the patient has tried prednisone for GREATER THAN or EQUAL to 6 months?
4. ☐ Yes ☐ No Is documentation being provided to confirm that, according to the prescriber, the patient has had a significant intolerable adverse effect (AE) [that is Cushingoid appearance, central {truncal} obesity, undesirable weight gain defined as a GREATER THAN or EQUAL TO 10% of body weight gain increase over a 6-month period; diabetes and/or hypertension that is difficult to manage according to the prescriber]?
5. ☐ Yes ☐ No Is documentation being provided to confirm that, according to the prescriber, the patient has experienced a severe behavioral adverse effect (AE) while on prednisone therapy that has or would require a prednisone dose reduction?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851