maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Emflaza

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient currently receiving Emflaza/Deflazacort? [If no, skip to question 4]	Yes	No
2	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 4]	Yes	No
3	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
4	What is the diagnosis or indication?		

If you have any questions, call:
1-888-258-8250

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	[] Duchenne Muscular Dystrophy (DMD) (If checked, go to 5)		
	[] Other (If checked, no further questions)		
5	What is the requested medication?		
	[] Deflazacort (generic) (If checked, go to 7)		
	[] Emflaza (brand) (If checked, go to 6)		
6	Has the patient had a trial and failure of the generic product, deflazacort? [If no, no further questions]	Yes	No
7	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders? [If no, no further questions.]	Yes	No
9	Is documentation being provided to confirm that the patient has tried prednisone for GREATER THAN or EQUAL to 6 months? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
10	Is documentation being provided to confirm that, according to the prescriber, the patient has had a significant intolerable adverse effect (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)? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
11	Is documentation being provided to confirm that, according to the prescriber, the patient has experienced a severe behavioral adverse effect while on prednisone therapy that has or would require a prednisone dose reduction? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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