

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Emflaza (deflazacort)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

	Prescriber Name:		
Patient Name:	Supervising Physician:		
Member/Subscriber Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Group Number:	NPI:	State Lic ID:	
Address: Address:			
City, State ZIP:	City, State ZIP:		
Primary Phone:	Specialty/facility name (if	applicable):	
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.			
Q1. For what diagnosis is the drug being prescribed	d (pick one)?		
☐ Duchenne Muscle Dystrophy			
☐ Other			
Q2. Please provide ICD code(s) for diagnosis.			
Q3. Is the prescriber a Neurologist?			
☐ Yes ☐ No			
Q4. Does patient have documentation of mutation	of the dystrophin gene? (Please	provide documentation)	
☐ Yes ☐ No			
Q5. Is the patient 5 years of age or older?			
☐ Yes ☐ No			
Q6. Did onset of weakness occur before 5 years of	age? (Please provide documer	ntation)	
☐ Yes ☐ No			



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Patient Name:	Prescriber Name: Supervising Physician:	
Q7. Has patient had serum creatinine kinase activity at least 10 times the upper limit of normal at some point in their illness? (Please provide documentation)		
☐ Yes ☐ No	Unknown	
Q8. Has the patient tried prednisone for at least 6 months (documentation of 6 months of prednisone therapy require The patient developed Cushingoid appearance (documentation)	d) Please select all of the following that apply:	
 ☐ The patient developed central (truncal) obesity (documentation required) ☐ The patient developed an undesirable weight gain, defined as an increase in body weight of 10% or greater over a 6-month period (documentation required) ☐ None of the above 		
Q9. If patient experienced adverse effects on prednisone, did a dose reduction (e.g. 0.3 mg/kg/day) result in improvement of intolerable adverse effects? ☐ Yes ☐ No		
Q10. Additional comments		
Prescriber Signature	Date	

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.



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