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.**

Patient Name:		**Prescriber 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 (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 documentation)

☐ Yes ☐ No

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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 and developed any of the following adverse effects? (documentation of 6 months of prednisone therapy required) Please select all of the following that apply:

☐ The patient developed Cushingoid appearance (documentation required)

☐ 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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