https://providers.amerigroup.com

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Deflazacort (Emflaza)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 1-844-512-9004 Provider Help Desk 1-800-454-3730

1. Patient information

Patient name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient phone #: _____

Patient email address: _____

2. Physician information

Prescribing physician: _____

Physician address: _____

Physician phone #: _____

Physician fax #: _____

Physician specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for Emflaza (deflazacort). Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene; and 2) Patient is within the FDA labeled age; and 3) Patient experienced onset of weakness before 5 years of age; and 4) Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and 5) Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose; and 6) Is dosed based on FDA approved dosing. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Documented mutation of the dystrophin gene? ☐ Yes (attach documentation) ☐ No

Patient's current weight (kg): _____ Patient's age at onset of weakness: _____

Does prescriber specialize in treatment of DMD?

☐ Yes ☐ No If no, note consultation with physician who specializes in treatment of DMD:

Consultation date: _____ Physician name & phone: _____

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Patient name:_____ **Patient ID #:** _____

Prednisone trial: Drug name/dose: _____

Trial start date:_____Trial end date:_____Reason

for failure: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Patient name:_____ **Patient ID #:** _____

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.