





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

2. Physician information

1. Patient information					
Patient name:		Prescribing physician:			
Patient ID #:		Physician address:			
Patient DOB:		Physician phone #:			
Date of Rx:		Physician fax #:			
Patient phone #:		Physician specialty:			
		Physician DEA:			
Patient email address:		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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IAPEC-1178-18 October 2018







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Patient name:		Patient ID #:		
	me/dose:			
Trial start date:	Trial end date:		Reason	
for failure:				
Medical or contraindication	on reason to override trial rec	quirements:		
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 no	ot the practice of medicine or the substitu	ite for the independent medical judgi	nent of a treating physician. Only a treat	ıng physician

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.

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