



Emflaza Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information

2. Physician information

Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

Emflaza	<input type="checkbox"/> 18 mg tablet	_____	Specify: _____
	<input type="checkbox"/> 22.75 mg/ml oral susp		
	<input type="checkbox"/> 30 mg tablet		
	<input type="checkbox"/> 36 mg tablet		
	<input type="checkbox"/> 6 mg tablet		

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.)

Initial request:

Yes No Patient has had a diagnosis of Duchenne muscular dystrophy (DMD) in the last 730 days.

Yes No Medication is being prescribed by, or in consultation with, a neurologist.

Yes No Patient has tried prednisone for greater than or equal to 6 months, AND has one of the following adverse events as a result of prednisone use:

- Cushingoid appearance
- Central (truncal) obesity
- Undesirable weight gain (defined as greater than or equal to 10% body weight gain over a 6-month period)
- Diabetes and/or hypertension that is difficult to manage according to the prescribing physician

Yes No Client has experienced a severe behavioral adverse event while on prednisone therapy that has or will require a prednisone dose reduction

Renewal requests:

- Yes No The medication is being prescribed by, or in consultation with, a neurologist.
- Yes No The physician states that the client continues to have a positive response to therapy.

All requests:

- Yes No Patient has a claim for a moderate or strong CYP3A4 inducer in the last 90 days.
- Yes No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
- Yes No Patient has a documented allergy or contraindication to preferred agents in this class.
- Yes No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs>.

9. Physician signature

Prescriber or authorized signature

Date

PA 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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