Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Emflaza® (deflazacort) Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed.
Please complete one form per member.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Member's weight: __________kg

Is this a reauthorization request through Georgia Medicaid Fee-for-Service? ❑ **Yes** ❑ **No**
If yes, please attach documentation demonstrating the member has had a positive clinical response to Emflaza (deflazacort) therapy such as improvement or stabilization of muscle strength or pulmonary function.

For initial prior authorization requests, please provide responses to the questions below:

What is the member's diagnosis? ____

Has the diagnosis been confirmed by a mutation in the dystrophin gene? ❑ **Yes** ❑ **No**

Is the medication being prescribed by or in consultation with a physician who specializes in Duchenne muscular dystrophy? ❑ **Yes** ❑ **No**

Has the member failed prednisone after at least 3 months of therapy? ❑ **Yes** ❑ **No**
*If **yes**, please provide the start and end dates of prednisone therapy along with dose used below:*

____

Does the member have an allergy, contraindication, drug-drug interaction or intolerable side effect with prednisone that is not expected to occur with Emflaza (deflazacort)? ❑ **Yes** ❑ **No**
Please provide specific information regarding the allergy, contraindication, drug-drug interaction or intolerable side effect below and attach chart documentation. For example, if patient has experienced clinically significant weight gain/obesity while receiving prednisone, chart documentation of weight gain/obesity must be attached. Chart documentation of weight gain leveling off after switching to Emflaza (deflazacort) must also be attached.

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This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Emflaza® (deflazacort) Prior Authorization Request Form (Page 2 of 2)

In the space below, please provide letter of medical necessity and any additional information you deem clinically relevant in evaluating the prior authorization request. You may attach this information separately as well.

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I attest that this information is accurate and true and that documentation supporting this information is available for review if requested by the Department of Community Health.

Physician Signature**:** ___________________________

Contact Person: _______________________________ Phone: ____________________________

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____
____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.

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