

**NC Medicaid
Pharmacy Prior Approval Request for
Emflaza and generic deflazacort**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request- up to 30 Days 60 Days 90 Days 120 Days 180 Days
Reauthorization Request- up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

Initial Authorization Request:

1. Is the beneficiary age 2 or older? Yes No
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required)?
 Yes No
3. Has the beneficiary tried prednisone? Yes No
Answer questions 3a and 3b when the response to question 3 is 'Yes'.
3a. Has the beneficiary had an inadequate treatment response to prednisone? If yes, documentation is required. Yes No
3b. Has the beneficiary experienced unmanageable and clinically significant side effects such as significant weight gain/obesity, persistent psychiatric/behavioral issues, diabetes, hypertension, or Cushingoid appearance? If yes, documentation required. Yes No
4. A baseline motor milestone assessment is required. Please select all that apply and submit documentation:
 6-minute walk test (6MWT)
 North Star Ambulatory Assessment (NSAA)
 Motor Function Measure (MFM)
 Hammersmith Functional Motor Scale (HFMS)
 Other – Please Explain: _____
 None of the above
5. Is the medication prescribed by or in consultation with a neurologist? Yes No
6. Will the provider ensure that Emflaza is not being given concurrently with live vaccinations? Yes No
7. Is Emflaza dosing for Duchenne Muscular Dystrophy in accordance with the USFDA approved labeling? Yes No

Reauthorization Request:

Please check all of the applicable clinical benefits the beneficiary has received from Emflaza therapy (Please submit documentation for each):

8. A baseline motor milestone assessment is required. Please select all that apply and submit documentation.
 Stabilization, maintenance or improvement of muscle strength
 Stabilization, maintenance or improvement of pulmonary function
 Improvement in motor milestone assessment scores from baseline testing
 Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy
 Other – Please Explain: _____
 None of the above

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866)246-8505DHB Pharmacy