

NC DHB Pharmacy Request for Prior Approval
Emflaza



Recipient Information

DMA-3607 (V02)

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

Prescriber Information

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

Drug Information

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

Clinical Information - Documentation is required for all Emflaza PA Requests.

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.
- 4a. 6-minute walk test (6MWT)
 - 4b. North Star Ambulatory Assessment (NSAA)
 - 4c. Motor Function Measure (MFM)
 - 4d. Hammersmith Functional Motor Scale (HFMS)
 - 4e. Other
- Please explain: _____
- 4f. 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.
- 8a. Stabilization, maintenance or improvement of muscle strength
 - 8b. Stabilization, maintenance or improvement of pulmonary function
 - 8c. Improvement in motor milestone assessment scores from baseline testing
 - 8d. Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy
 - 8e. Other
- Please explain: _____
- 8f. None of the above

Signature of Prescriber: _____ Date: _____

*Prescriber signature mandatory

Fax this form to NCTracks at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505