



NC DHB Pharmacy Request for Prior Approval - Emflaza

Recipient Information

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: NPI: or Atypical: 8. Prescriber DEA #: 9. Requester Contact Information: Name: Phone #: Ext:

Drug Information

10. Drug Name: EMFLAZA 11. Strength: 12. Quantity Per 30 Days: 13. 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 5 or older? 2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required)? 3. Has the beneficiary tried prednisone? 3a. Has the beneficiary had an inadequate treatment response to prednisone? 3b. Has the beneficiary experienced unmanageable and clinically significant side effects... 4. A baseline motor milestone assessment is required. 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 4f. None of the above Please explain: 5. Is the medication prescribed by or in consultation with a neurologist? 6. Will the provider ensure that Emflaza is not being given concurrently with live vaccinations? 7. Is Emflaza dosing for Duchenne Muscular Dystrophy in accordance with the USFDA approved labeling?

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**

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: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318