AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Emflaza

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: 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 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 for each.**
___ 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 the 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406