



Please complete ALL information below and fax your request to 1-888-671-5285

Emflaza® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Duchenne muscular dystrophy (DMD)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Prescriber specialty:	
Is Emflaza prescribed by or in consultation with a neurologist who has experience treating children? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Clinical information:	
Select if the patient has a diagnosis of Duchenne muscular dystrophy (DMD) as confirmed by the following:	
<input type="checkbox"/> Mutation of the dystrophin gene	
<input type="checkbox"/> Absence of the dystrophin protein confirmed by muscle biopsy	
Has the patient had an inadequate response or inability to tolerate prednisone or prednisolone given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will the patient's dose exceed 0.9 mg/kg of body weight once daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reauthorization:	
Will the patient's dose exceed 0.9 mg/kg of body weight once daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient experienced a benefit from therapy (e.g., improvement or preservation of muscle strength)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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.

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