FUTURE SCRIPTS

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

Emflaza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Duchenne muscular dystrophy (DMD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber specialty:

Is Emflaza prescribed by or in consultation with a neurologist who has experience treating children? ❑ **Yes** ❑ **No**

Clinical information:

Select if the patient has a diagnosis of Duchenne muscular dystrophy (DMD) as confirmed by the following:

- ❑ Mutation of the dystrophin gene
- ❑ 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? ❑ **Yes** ❑ **No**

Will the patient's dose exceed 0.9 mg/kg of body weight once daily? ❑ **Yes** ❑ **No**

Reauthorization:

Will the patient's dose exceed 0.9 mg/kg of body weight once daily? ❑ **Yes** ❑ **No**

Has the patient experienced a benefit from therapy (e.g., improvement or preservation of muscle strength)? ❑ **Yes** ❑ **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.