EMFLAZA®
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Please select the patient's diagnosis:
- ☐ Duchenne muscular dystrophy (DMD)*

*** Please provide documentation of genetic test to confirm diagnosis of DMD**

- ☐ Other (ICD code, plus description): _____

Patient's Weight (kg):

Medication Requested:	Strength(s):
Dosing Schedule:	Quantity per Month (of each strength):

For ALL Requests:

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Has the patient tried and failed a generic prednisone or prednisolone?..... ☐ Yes ☐ No
   If yes, please provide dates of treatment: Start Date: _____ End Date: _____
3. Does the patient have a documented adverse reaction, intolerance, or contraindication to therapy with generic prednisone that is NOT expected to occur with the requested medication? ..... ☐ Yes ☐ No
   If yes, please submit supporting documentation.
4. Has the patient tried a moderate or strong CYP34A inducer? ..... ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
5. Please list all reasons for selecting the requested **medication, dosing schedule, and quantity** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried): _____
6. Please list all other medications the patient is **currently taking** for treatment of this diagnosis: _____
7. Please list all medications the patient has **previously tried and failed** for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

8. Please list all other medications the patient will be taking **in combination** with the requested medication for this diagnosis.

Please continue to page 2.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For Renewal Requests:

9. Does the prescriber attest that the patient had a positive response to therapy with Emflaza (deflazacort)?... ☐ Yes ☐ No

Prescriber or Authorized Signature: _____ Date: _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.0407

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