Wellpoint

Emflaza Prior Authorization of Benefits Form

Contains confidential patient information
Complete form in its entirety and fax to Prior Authorization of Benefits Center at **844-474-3341**.

1. Patient information	**2. Physician information**
Patient name:	Prescribing physician:
Patient ID #:	Physician address:
Patient DOB:	Physician phone #:
Date of Rx:	Physician fax #:
Patient phone #:	Physician specialty:
Patient email address:	Physician DEA:
	Physician NPI #:
	Physician email address:

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Emflaza	☐ 18 mg tablet ☐ 22.75 mg/ml oral susp ☐ 30 mg tablet ☐ 36 mg tablet ☐ 6 mg tablet	_____	Specify:
7. Diagnosis _____			

8. Approval criteria: Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Initial request
☐ Yes ☐ No Patient has had a diagnosis of Duchenne muscular dystrophy (DMD) in the last 730 days.
☐ Yes ☐ No Patient has tried prednisone for greater than or equal to 6 months, AND has one of the following adverse events as a result of prednisone use:
- ☐ Cushingoid appearance
- ☐ Central (truncal) obesity
- ☐ Undesirable weight gain (defined as greater than or equal to 10% body weight gain over a 6-month period)
- ☐ Diabetes and/or hypertension that is difficult to manage according to the prescribing physician

☐ Yes ☐ No Client has experienced a severe behavioral adverse event while on prednisone therapy that has or will require a prednisone dose reduction.

Renewal requests:
☐ Yes ☐ No The medication is being prescribed by, or in consultation with, a neurologist.
☐ Yes ☐ No The physician states that the client continues to have a positive response to therapy.

All requests:
☐ Yes ☐ No Patient has a claim for a moderate or strong CYP3A4 inducer in the last 90 days.
☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent(s) within the past 180 days.
☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class.
☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

_____	_____
Prescriber or authorized signature	*Date*

PA 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.
Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.