NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
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NC DHB Pharmacy Request for Prior Approval - Emflaza

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information: Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **EMFLAZA** 10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information - Documentation is required for all Emflaza PA Requests.

Initial Authorization Request:

1. Is the beneficiary age 5 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 is 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.
   - 4a. 6-minute walk test (6MWT) ☐
   - 4b. North Star Ambulatory Assessment (NSAA) ☐
   - 4c. Motor Function Measure (MFM) ☐
   - 4d. Hammersmith Functional Motor Scale (HFMS) ☐
   - 4e. Other ☐
     Please explain: _____
   - 4f. None of the above ☐

5. Is the medication prescribed by or in consultation with a neurologist? ☐ Yes ☐ No
6. Will the provider ensure that 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.

- 8a. Stabilization, maintenance or improvement of muscle strength ☐
- 8b. Stabilization, maintenance or improvement of pulmonary function ☐
- 8c. Improvement in motor milestone assessment scores from baseline testing ☐
- 8d. Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy ☐
- 8e. Other ☐
  Please explain: _____
- 8f. 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: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**