

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Emflaza (deflazacort) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

## **Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Emflaza (deflazacort).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: <u>1-866-331-2104</u>]. If you have any questions or concerns, please call <u>1-866-331-2103</u>. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <a href="http://www.providers.kaiserpermanente.org/mas/formulary.html">http://www.providers.kaiserpermanente.org/mas/formulary.html</a>** 

1 – Patient Information				
Patient Name:	Kaiser Medical ID#:	Date of Birth:		
2 – Provider Information				
Is the prescriber a neurologist and experienced in the treatment of muscular dystrophy? $\Box$ No $\Box$ Yes				
If consulted with a specialist, specialist name and specialty:				
Provider Name:	Specialty:	Provider NPI:		
Provider Address:				
Provider Phone #:	Provider Fax #:			
Please check the boxes that apply:  □ Initial Request □ Continuation of Therapy Request				
3 – Pharmacy Information				
Pharmacy Name:	Pharmacy NPI:			
Pharmacy Phone #	Pharmacy Fax #:			
4 – Drug Therapy Requested				
Drug 1: Name/Strength/Formulation: _				
Drug 2: Name/Strength/Formulation:				

## 5- Diagnosis/Clinical Criteria

Initial <sup>-</sup>	Therapy:		
1.	Member has diagnosis of Duchenne Muscular Dystrophy (DMD) with confirmatory genetic testing AND		
	□ No □ Yes		
2.	Is the member ≥ 5 years? <b>AND</b>		
	□ No □ Yes		
3.	Member has used prednisone for at least 12 months.		
	□ No □ Yes		
Contin	nuation of Therapy:		
1.	1. Member has Hgb A1C, blood pressure, and BMI monitored over the last 12 months, AND		
	□ No □ Yes		
2.	. Member is not experiencing persistent or worsening abnormal weight gain ≥5	50% improvement in MIDAS scores	
	□ No □ Yes		
	7 – Provider Sign-Off		
Additional Information – Please provide any additional information that should be taken into consideration.			
I cert	tify that the information provided is accurate. Supporting documentation is available	for State audits.	
Provider Signature:		ate:	
Planca Na	Note: This decument contains confidential information, including protected health information, intended for a	specific individual and purpose. The information is	

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