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: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html**

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? □ No □ 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: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Member has diagnosis of Duchenne Muscular Dystrophy (DMD) with confirmatory genetic testing **AND**
   □ No □ Yes
2. Is the member ≥ 5 years? **AND**
   □ No □ Yes
3. Member has used prednisone for at least 12 months.
   □ No □ Yes

Continuation of Therapy:

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 ≥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 certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**