

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 experience	ed in the treatment of muscular dystr	ophy? □ 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:			
3ig			
Drug 2: Name/Strength/Formulation:			
Sig:			

## 5- Diagnosis/Clinical Criteria

nitial '	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	uation of Therapy:		
1.	<ol> <li>Member has Hgb A1C, blood pressure, and BMI monitored over the last 12 months, AND</li> <li>No □ Yes</li> </ol>		
2.	Member is not experiencing persistent or worsening abnormal weight gain ≥50% improvement in MIDAS scores  □ No □ Yes		
	7 – Provider Sign-Off		
Additio	onal Information – Please provide any additional information that should be taken into consideration.		
l cert	ify that the information provided is accurate. Supporting documentation is available for State audits.		
Provide	er Signature: Date:		
Dlaaca N	te: This document contains confidential information, including protected health information, intended for a specific individual and nurnose. The information	n ic	

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