Texas Medicaid/CHIP Vendor Drug Program
Fee-For-Service Clinical Prior Authorization Request Form
Emflaza

About
This document contains information about prior authorization criteria for Emflaza (deflazacort). Deflazacort is FDA-approved for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

Treatment Approval Criteria for Emflaza (deflazacort)
- Client 2 years of age or older with a diagnosis of Duchenne muscular dystrophy
- Therapy prescribed by, or in consultation with, a neurologist
- Client has tried prednisone for 6 months or longer and has one of the following adverse events as a result of prednisone use:
    - Cushingoid appearance
    - Central (truncal) obesity
    - Undesirable weight gain (greater than or equal to 10% body weight gain over a 6-month period)
    - Diabetes and/or hypertension that is difficult to manage
    - Experienced a severe behavioral adverse event
- For renewal requests
    - Please fill out sections 1, 5, and 6

Denial Criteria
Reasons for denial include but are not limited to the following**:**
- Age less than 2 years
- Not prescribed by or in consultation with a neurologist
- Non-FDA approved indications
- No previous trial with prednisone

Medicaid Fee-For-Service Clients: This form should be used only for the Medicaid Fee-for-Service (FFS) clients. Using this form for clients not enrolled in FFS clients may lead to unnecessary delays in access to treatment.

Managed Care Medicaid Clients: For prior authorization information for Medicaid clients enrolled in a Managed Care Organization (MCO), please contact the appropriate health plan. Please refer to the Prescriber Assistance Chart at TxVendorDrug.com/claims/managed-care.shtml to obtain the MCO prior authorization instructions and contact information.

Please fax the completed form to the Texas Prior Authorization Call Center at 1-866-617-8864.

Texas Medicaid/CHIP Vendor Drug Program
Fee-For-Service Clinical Prior Authorization Request Form
Emflaza

Section 1 - Patient Information

First Name:		Last Name:	MI:
DOB:	Medicaid ID:	Drug allergies:	

Section 2 - Patient History

Required Diagnosis (please check one of the following):	
☐ ICD-9: 359.1 Hereditary Progressive Muscular Dystrophy ☐ ICD-10: G71.0 Muscular Dystrophy	Date of diagnosis:

Section 3 – Drug Treatment History (If renewal request, please skip to section 5)

Drug	Last prescribed dose	Start date	End date
☐ prednisone			
☐ other (list drug name(s) below)			

Section 4 - Treatment Information (If renewal request, please skip to section 5)

Prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No	
Name of specialist:	Date of consult:
Client has tried prednisone for greater than or equal to (≥) 6 months	☐ Yes ☐ No
Client has had one of the following adverse events as a result of prednisone therapy:	Date of Diagnosis:
☐ Cushingoid appearance	
☐ Central (truncal) obesity	
☐ Undesirable weight gain (greater than or equal to [≥] 10 % of body weight gain over a 6-month period)	
☐ Diabetes and/or hypertension that is difficult to manage	
☐ Experienced a severe behavioral adverse event	

Section 5 – Renewal Information

Client continues to have a positive response to Emflaza therapy: ☐ Yes ☐ No

Texas Medicaid/CHIP Vendor Drug Program
Fee-For-Service Clinical Prior Authorization Request Form
Emflaza

Section 6 - Prescriber Information and Signature

<table>
<tr><td colspan="3">Prescriber Name (Last, First):</td><td colspan="3">Prescriber NPI:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td>Prescriber license:</td><td colspan="2">Specialty (if applicable):</td><td colspan="3">Office Phone:</td></tr>
<tr><td colspan="3">Preparer Name (if other than prescriber):</td><td colspan="3">Office Fax:</td></tr>
<tr><td colspan="3">Prescriber Signature:</td><td colspan="3">Date:</td></tr>
</table>

Please fax the completed form to the Texas Prior Authorization Call Center at 1-866-617-8864.
Prescribers with questions regarding this form may call the Texas Prior Authorization Call Center at **1-877-728-3927**