Texas Vendor Drug Program

Emflaza Standard Prior Authorization Addendum (Medicaid)

Complete and fax both the Texas Standard Prior Authorization Request Form for Prescription Drug Benefits (TDI Form NOFR002) (PDF) and Form 1347 to the Texas Prior Authorization Call Center at 866-469-8590. Incomplete forms or failure to submit this addendum may cause delays in patient care and prior authorization denial. This form is only for patients enrolled in Medicaid fee-for-service. Using this form for people in Medicaid-managed care or other programs may lead to unnecessary delays in access to treatment.

Medicaid managed care: Contact the managed care organization (MCO) for forms and instructions for patients enrolled in managed care. Refer to the **MCO Assistance Chart** for each MCO's prior authorization contact information.

This form contains information about prior authorization criteria for Emflaza (deflazacort). The drug is approved for the treatment of Duchenne muscular dystrophy in patients 2 years and older. For the complete Emflaza prior authorization policy, refer to the Texas Emflaza Prior Authorization Criteria Guide.

For prior authorization renewal requests, complete Sections I, V and VI.

Approval Criteria

- 2 years or older with a diagnosis of Duchenne muscular dystrophy
- Tried prednisone for three months or longer and has one of the following adverse events because of prednisone use:
  - Cushingoid appearance
  - Central (truncal) obesity
  - Undesirable weight gain (greater than or equal to 10% body weight gain over six months)
  - Diabetes or hypertension is difficult to manage
- Experience severe behavioral adverse events due to steroids use

Denial Criteria

Reasons for denial include, but are not limited to:

- Age less than 2 years
- Non-FDA approved indications
- Use of CYP3A4 in last 90 days
- No previous trial with prednisone

Section I – Patient Information		
Patient Name (First, Last, MI)	Medicaid ID No.	Date of Birth (MM/DD/YY)
Drug Allergies		

Section II – Patient History *(For authorization renewal requests, skip to Sections V and VI.)*	
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 III – Drug Treatment History

Drug	Last Prescribed Dose	Start Date	End Date	
Prednisone				
Other *(List drug name(s) below)*:				

+–Doestheclienthaveaclaimformoderate tostrong CYP3A4inducer inthepast 90days?Yes

No**Section IV–TreatmentInformati**

onPatienthastriedprednisoneforgreaterthan orequal to (t) three months? Yes

No**Patienthashadone ofthefollowingadverseeventsbecause ofprednisonetherapy:Date**	**ofDiagnos**
is Cushingoidappearan	
ceCentral(truncal)obesi	
tyUndesirableweightgain(greaterthan orequal to [≥] 10% ofbodyweightgainsix-month	
s)Diabetes orhypertensionthat isdifficult tomana	
gePatientexperiencedaseverebehavioraladverseeventbecause ofsteroidtherap	

y.**Section V–PriorAuthorizationRenew**

alPatientcontinues tohaveapositiveresponse to Emflazatherapy:Yes

NoDoestheclienthaveaclaimformoderate tostrong CYP3A4inducer inthepast 90days?Yes

No**Section VI–PrescriberInformationandSignatu**

rePrescriberNamePrescriber	NPIPrescriberLicen	
seAddress(Stre$_{e}$t,Ci$_{t}$y,StateandZIPCod		
e)PreparerName (ifotherthanprescriber)OfficeAreaCodeandPhone		No.OfficeAreaCodeandFaxN
o.PrescriberSignatureDate		