NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Emflaza

Beneficiary Information

1. Beneficiary Last Name: ___________________________________ 2. First Name: ____
3. Beneficiary ID #: ________________________ 4. Beneficiary Date of Birth: ________________________ 5. Beneficiary Gender: __________

Prescriber Information

6. Prescribing Provider NPI #: ____
7. Requester Contact Information - Name: _________________________ Phone #: ___________________ Ext. _________________________

Drug Information

8. Drug Name: ____________________________________ 9. Strength: _____________________ 10. Quantity Per 30 Days:_______________
11. Length of Therapy (in days): Initial Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Reauthorization Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial Authorization Request:

1. Is the beneficiary age 2 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required)? ☐ **Yes** ☐ **No**

3 Has the beneficiary tried prednisone? ☐ **Yes** ☐ **No**
Answer questions 3a and 3b when the response to question 3 is 'Yes'.
3a. Has the beneficiary had an inadequate treatment response to prednisone? If yes, documentation is required. ☐ **Yes** ☐ **No**
3b. Has the beneficiary experienced unmanageable and clinically significant side effects such as significant weight gain/obesity, persistent psychiatric/behavioral issues, diabetes, hypertension, or Cushingoid appearance? If yes, documentation required. ☐ **Yes** ☐ **No**

4. A baseline motor milestone assessment is required. Please select all that apply and submit documentation:
   - ☐ 6-minute walk test (6MWT)
   - ☐ North Star Ambulatory Assessment (NSAA)
   - ☐ Motor Function Measure (MFM)
   - ☐ Hammersmith Functional Motor Scale (HFMS)
   - ☐ Other – Please Explain: ____
   - ☐ None of the above
5. Is the medication prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
6. Will the provider ensure that Emflaza is not being given concurrently with live vaccinations? ☐ **Yes** ☐ **No**
7. Is Emflaza dosing for Duchenne Muscular Dystrophy in accordance with the USFDA approved labeling? ☐ **Yes** ☐ **No**

Reauthorization Request:
Please check all of the applicable clinical benefits the beneficiary has received from Emflaza therapy (Please submit documentation for each):
8. A baseline motor milestone assessment is required. Please select all that apply and submit documentation. 8a. Stabilization, maintenance or improvement of muscle strength
   - ☐ Stabilization, maintenance or improvement of pulmonary function
   - ☐ Improvement in motor milestone assessment scores from baseline testing
   - ☐ Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy
   - ☐ Other – Please Explain: ____
   - ☐ None of the above

Signature of Prescriber: ____ Date: __________________________

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505