Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Emflaza (deflazacort)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Current Member Weight:	Requested Dose:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

INITIATION OF THERAPY

1. Member must be ≥ 2 years of age with confirmed diagnosis of DMD (Duchenne Muscular Dystrophy) AND medication is prescribed by a provider who specializes in the treatment of DMD: ☐ Yes ☐ No
2. At least one of the following statements are true:

   ☐ The member has experienced a severe behavioral adverse effect while on prednisone therapy that has or would require a prednisone dose reduction **(CHART NOTES MUST BE PROVIDED THAT POSITIVELY DOCUMENT THE ADVERSE EFFECT)**

   ☐ The member has tried prednisone for ≥ 6 months and has had at least one of the following significant intolerable adverse effects that is unable to be managed: **(CHART NOTES MUST BE PROVIDED THAT POSITIVELY DOCUMENT THE ADVERSE EFFECT)**

   - Cushingoid appearance
   - Central (truncal) obesity
   - Weight gain of at least 10% of body weight over a 6-month period
   - Diabetes and/or hypertension that is difficult to manage

Quantity Limitations: Authorization will be based on a maximum of 0.9 mg/kg/day with dose optimization required.

Initial authorization will be issued for 6 months.

CONTINUATION OF THERAPY

1. Coverage can be renewed when a clear benefit to the use of Emflaza has been shown compared to other available corticosteroids (i.e. reduction in Cushingoid appearance, reduction in the rate of weight gain). **CHART NOTES MUST BE PROVIDED TO SHOW AN OBJECTIVE BENEFIT.** ☐ Yes ☐ No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Medicaid Drug Prior Authorization Unit at 1-800-294-1350