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

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
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<tr>
<td>Current Member Weight:</td>
<td>Requested Dose:</td>
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<tr>
<td>Prescriber Name/Specialty if applicable:</td>
<td>Prescriber Fax:</td>
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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

1/2020