OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.***

Drug Requested: **Emflaza™** (deflazacort) ***(Non-Preferred)*** ***(MEDICAID)***

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ ***Length of Therapy:*** ______________________

Diagnosis: ______________________ ***ICD Code, if applicable:*** ______________________

***Length of Authorization*:** **1 year**

CLINICAL CRITERIA: Age Restriction applies. The following criteria MUST be met or authorization process will be delayed.

- ❑ Trial and failure of ***ALL*** drugs ***does not*** apply to Emflaza™
- ❑ Patient diagnosed with Duchenne muscular dystrophy (DMD)
- ❑ Patient is ≥ 5 years old
- ❑ Minimum Age Limit = 5 years of age

Medication be provided by a Specialty Pharmacy - PropriumRx

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ______________________________

Member Optima #: ______________________ Date of Birth: ______________________

Prescriber Name: ______________________________

Prescriber Signature: ______________________ Date: ______________________

Office Contact Name: ______________________________

Phone Number: ______________________ Fax Number: ______________________

DEA OR NPI #: ______________________________

UPDATED/REVISED: 7/1/2018