OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
MEDICAID

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)**

DRUG INFORMATION: Complete 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: ~~6/29/2017; 8/29/2017;~~ **8/18/2018**