

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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 information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Length of Authorization: 1 yr

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