OPTIMA HEALTH PLAN

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. If incomplete, authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

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

CLINICAL CRITERIA: ***Check applicable boxes below to qualify. Authorization process will be delayed if not completed.*** ***Chart notes must be submitted supporting each criterion.***

Initial Approval: ***Approved for 6 months***

- ❑ Patient is ≥ 5 years old

AND

- ❑ Diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by documented presence of abnormal dystrophin or confirmed mutation of dystrophin gene

AND

- ❑ Therapy prescribed by or in consultation with a physician who specializes in the treatment of DMD

AND

- ❑ Serum creatinine kinase activity at least 10 times the upper limit of normal at some stage of the illness prior to initiating therapy

AND

- ❑ Minimum of six month trial of prednisone and
  - ❑ At least **one** significant intolerable adverse effect occurred:
    - Cushingoid appearance
    - Truncal obesity
    - Undesirable weight gain (≥ 10% body weight gain increase over a 6-month period)
    - Diabetes and/or hypertension that is difficult to manage

OR

- ❑ Patient has experienced a severe behavioral adverse event while on prednisone that required or will require a reduction in prednisone dose
  - Behavioral adverse event persisted beyond the first 6 weeks of prednisone therapy

AND

  - Change in the time of prednisone administration was attempted and was unsuccessful

AND

  - Baseline motorassessed with milestone score from one of the following:
    - 6-Minute Walk Test (6MWT)
    - North Star Ambulatory Assessment (NSAA)
    - Hammersmith Functional Motor Scale (HFMS)

AND

(continued on next page)

- Therapy will not be used concurrently with live vaccines

AND

- Active infection is absent

AND

- History of HBV Infection? ❑ Yes ❑ No
  Will monitor HBV reactivation

AND

- Dose does not exceed 0.9 mg/kg/day

Renewal Approval: ***Approved for 12 months***

- Diabetes and/or hypertension management
- Behavior

AND

- Therapy will not be used concurrently with live vaccines

AND

- Active infection is absent

AND

- History of HBV Infection? ❑ Yes ❑ No
  - Will monitor for HBV reactivation

AND

- Dose does not exceed 0.9 mg/kg/day

Medication being provided by a Specialty Pharmacy: ❑ **Briova Specialty**

****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; 9/13/2017;~~ **10/6/2017**;