

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 ($\geq 10\%$ 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?
Will monitor HBV reactivation

Yes No

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?
 - Will monitor for HBV reactivation

Yes No

AND

- Dose does not exceed 0.9 mg/kg/day

Medication being 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; 8/3/2017