AvMed

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 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Emflaza® (deflazacort)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Recommended dosage: 0.9mg/kg, 1 dose once daily

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization - 6 months

- ❑ Member is 2 years of age or older

AND

- ❑ Member has a diagnosis of Duchenne Muscular Dystrophy (DMD) confirmed by documented presence of abnormal dystrophin or confirmed mutation of dystrophin gene **(submit documentation)**

AND

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

AND

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

AND

- ❑ Member has had a minimum of **SIX** months trial of prednisone **(verified by chart notes or pharmacy paid claims)**

AND

- ❑ Member had at least **ONE** of the following significant intolerable adverse effect due to prednisone therapy:
  - ❑ 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

  - ❑ Member has experienced a severe behavioral adverse event while on prednisone that required or will require a reduction in prednisone dose with **BOTH** of the following:
    - ❑ Behavioral adverse event persisted beyond the first 6 weeks of prednisone therapy
    - ❑ Change in the time of prednisone administration was attempted and was unsuccessful

AND

- ❑ Baseline motor assessed with milestone score from **ONE** of the following has been performed:
  - ❑ 6-Minute Walk Test (6MWT)
  - ❑ North Star Ambulatory Assessment (NSAA)
  - ❑ Hammersmith Functional Motor Scale (HFMS)
  - ❑ Motor Function Measure (MFM)

AND

- ❑ Therapy will not be used concurrently with live vaccines

AND

- ❑ Active infection is absent

AND

- ❑ Does the member have a history of HBV Infection? ❑ Yes ❑ No
  - ❑ If **YES**, member will be monitored for reactivation of HBV

AND

- ❑ Dose does not exceed 0.9 mg/kg/day

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UPDATED/REVISED/REFORMATTED: ~~6/29/2017; 8/3/2017; 5/4/2018; 10/14/2019;6/21/2022;~~ **10/27/2023**;

Reauthorization - 12 months. All criteria must be checked for approval. To support each line checked, all documentation (lab results, diagnostics, and/or chart notes) must be provided or request may be denied.

- ❑ Member must have improvement or stabilization from baseline motor assessment milestone score of **ONE** of the following:
  - ❑ 6MWT
  - ❑ NSAA
  - ❑ MFM
  - ❑ HFMS

AND

- ❑ Member must have reduction in intolerable side effects compared to prednisone with documentation of improvement in **ONE** of the following:
  - ❑ Cushingoid appearance
  - ❑ Truncal obesity
  - ❑ Weight gain
  - ❑ Diabetes and/or hypertension management
  - ❑ Behavior

AND

- ❑ Therapy will not be used concurrently with live vaccines

AND

- ❑ Active infection is absent

AND

- ❑ Does the member have a history of HBV Infection? ❑ Yes ❑ No
  - ❑ IF **YES**, member will be monitored for reactivation of HBV

AND

- ❑ Dose does not exceed 0.9 mg/kg/day

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

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

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

UPDATED/REVISED/REFORMATTED: ~~6/29/2017; 8/3/2017; 5/4/2018; 10/14/2019;6/21/2022;~~ **10/27/2023**;