UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for Emflaza

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Reauthorization Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Initial Authorization Request:

1. Is the beneficiary age 2 or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required) ?
   ☐ **Yes** ☐ **No**
3. Has the beneficiary tried prednisone? ☐ **Yes** ☐ **No**
   Answer questions 3a and 3b when the response to question 3 is 'Yes'.
   3a. Has the beneficiary had an inadequate treatment response to prednisone? If yes, documentation is required. ☐ **Yes** ☐ **No**
   3b. Has the beneficiary experienced unmanageable and clinically significant side effects such as significant weight gain/obesity, persistent psychiatric/behavioral issues, diabetes, hypertension, or Cushingoid appearance? If yes, documentation required. ☐ **Yes** ☐ **No**
4. A baseline motor milestone assessment is required. Please select all that apply and submit documentation:
   ☐ 6-minute walk test (6MWT)
   ☐ North Star Ambulatory Assessment (NSAA)
   ☐ Motor Function Measure (MFM)
   ☐ Hammersmith Functional Motor Scale (HFMS)
   ☐ Other – Please Explain: _____
   ☐ None of the above
5. Is the medication prescribed by or in consultation with a neurologist? ☐ **Yes** ☐ **No**
6. Will the provider ensure that Emflaza is not being given concurrently with live vaccinations? ☐ **Yes** ☐ **No**
7. Is Emflaza dosing for Duchenne Muscular Dystrophy in accordance with the USFDA approved labeling? ☐ **Yes** ☐ **No**

Reauthorization Request:

Please check all of the applicable clinical benefits the beneficiary has received from Emflaza therapy (Please submit documentation for each):

8. A baseline motor milestone assessment is required. Please select all that apply and submit documentation. 8a. Stabilization, maintenance or improvement of muscle strength
   ☐ Stabilization, maintenance or improvement of pulmonary function
   ☐ Improvement in motor milestone assessment scores from baseline testing
   ☐ Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy
   ☐ Other – Please Explain: _____
   ☐ None of the above

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593