WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
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 if 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 U.S. FDA-approved labeling? ☐ **Yes** ☐ **No**

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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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**