Corticosteroids – Deflazacort (Emflaza)

Please provide the information below, print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082.

Apple Health Preferred Drug List: *https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

Date of request:			
Patient	Date of birth	Molina ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response [e.g. stabilization of muscle strength or pulmonary function]? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Duchenne muscular dystrophy confirmed by genetic testing
   ☐ Other. Specify: ________________

3. Does patient have a history of failure as stated below, contraindication, or intolerance to a 6-month trial of prednisone within the past 12 months defined by one of the following (check all that apply):
   ☐ Increase of 10 weight-for-age percentiles within the past 12 months
   ☐ Weight gain resulting in greater than or equal to the 85th weight-for-age percentile within the past 12 months
   ☐ Severe psychiatric adverse effects
   ☐ Other, contraindication or intolerance. Describe: ______________________

4. Was this prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

The following are required with this request:

- Chart notes
- Genetic testing confirming diagnosis

Prescriber signature	Prescriber specialty	Date