PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Emflaza - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Emflaza - Priority Partners MCO.

Drug Name (select from list of drugs shown)
EMFLAZA (deflazacort)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 9.]

2.	Does the patient have a diagnosis of Duchenne muscular dystrophy (DMD)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
3.	Was the patient diagnosed with Duchenne muscular dystrophy (DMD) by either of the following: A) a neurologist with expertise in the diagnosis of DMD, B) a physician in consultation with a neurologist with expertise in the diagnosis of DMD?	Y N
	[If no, no further questions.]	
4.	Is the patient 5 years of age or older?	Y N
	[If no, no further questions.]	
5.	Is the requested medication prescribed for a male patient?	Y N
	[If no, no further questions.]	
6.	Are there medical records (e.g., chart notes) confirming that the patient has a 6-minute walk time (6MWT)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Is there documentation of serum creatinine kinase activity at least 10 times the upper limit of normal (ULN)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
8.	Has the patient tried and failed at least 3 months of oral prednisone?	Y N
	NOTE: Submission of medical records is required.	
	[No further questions.]	
9.	Is there documentation showing a clinical improvement as a result of treatment?	Y N
	NOTE: Submission of medical records is required.	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date