Prior Authorization Request Form for
deflazacort (Emflaza)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of Duchenne Muscular Dystrophy?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by a neurologist?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 5 years of age?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried prednisone for at least 6 months and experienced unmanageable weight gain OR has experienced severe behavioral adverse events that requires a reduction in prednisone dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[02 August 2017]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: