TRICARE Prior Authorization Request Form for
deflazacort **(Emflaza)**

JOHNS HOPKINS
HEALTH PLANS
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. Is the patient greater than or equal to 2 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Duchenne Muscular Dystrophy?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
3. Has the diagnosis of Duchenne Muscular Dystrophy (DMD) been confirmed by genetic testing or muscle biopsy?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication being prescribed by a neurologist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to, OR an intolerability to prednisone?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. Has the patient experienced an inadequate response to a trial for AT LEAST 3 months of prednisone?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Does the provider acknowledges the FDA safety alerts, warnings, precautions, drug interactions, and monitoring recommendations for the requested medication?	☐ 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 Oct 2024]

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