Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue® | Medicaid

Emflaza Prior Authorization Form

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member 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): • Reauthorization Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days • Initial Request- ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days		
Clinical Information		
Initial Authorization Request:		
1. Is the member age 2 or older? ☐ Yes ☐ No		
2. Does the member have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required)? ☐ Yes ☐ No		
3. Has the member tried prednisone? ☐ Yes ☐ No Answer questions 3a and 3b when the response to question 3 is 'Yes'. 3a. Has the member had an inadequate treatment response to prednisone? If yes, documentation is required. ☐ Yes ☐ No 3b. Has the member 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 USFDA approved labeling? ☐ Yes ☐ No		
Reauthorization Request:		
Please check all of the applicable clinical benefits the member 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.		

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☐ 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 **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**