BlueCross BlueShield of North Carolina | HealthyBlue

Emflaza Prior Authorization Form

Member Information

1. Member Last Name:_____ 2. First Name:_____
3. Member ID #_____ 4. Member Date of Birth:_____
5. Member Gender:_____

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
Requester Contact Information: Name:_____ Phone #:_____ Ext:_____

Drug Information

8. Drug Name: **EMFLAZA** 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information - Documentation is required for all Emflaza PA Requests.

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.
   - 4a. 6-minute walk test (6MWT) ☐
   - 4b. North Star Ambulatory Assessment (NSAA) ☐
   - 4c. Motor Function Measure (MFM) ☐
   - 4d. Hammersmith Functional Motor Scale (HFMS) ☐
   - 4e. Other ☐
     Please explain:
     _____
   - 4f. 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.
   - 8a. Stabilization, maintenance or improvement of muscle strength ☐
   - 8b. Stabilization, maintenance or improvement of pulmonary function ☐
   - 8c. Improvement in motor milestone assessment scores from baseline testing ☐
   - 8d. Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy ☐
   - 8e. Other ☐
     Please explain:
     _____
   - 8f. None of the above ☐

https://provider.healthybluenc.com

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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 **1-844-376-2318**
Healthy Blue Pharmacy PA Call Center: **1-844-594-5072**