CVS caremark™ {{PANUMCODE}}

Emflaza

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Duchenne muscular dystrophy (DMD)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred product for your patient's health plan is prednisone and prednisolone. Can the patient's treatment be switched to a preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.***
   ❑ Yes - prednisone
   ❑ Yes - prednisolone
   ❑ No - continue request for Emflaza
4. Did the patient experience documented unmanageable and clinically significant weight gain or obesity while receiving treatment with any of the preferred products (prednisone or prednisolone)? ***ACTION REQUIRED: If Yes, attach chart documentation of weight gain or obesity (i.e., body mass index [BMI] or BMI percentile) while receiving treatment with prednisone or prednisolone.*** ❑ Yes ❑ No *If No, skip to #8*
5. What is/was the patient's age at the time of prednisone or prednisolone treatment? _____ years
6. *If patient is 2 years to 19 years of age,* what was the body mass index percentile while receiving treatment with prednisone or prednisolone? _____% *If 85th percentile or higher, skip to #10*
7. *If patient is 20 years of age or older,* what was the body mass index while receiving treatment with prednisone or prednisolone? _____ *If 25 or more, skip to #10*
8. Did the patient experience documented unmanageable and clinically significant psychiatric or behavioral issues while receiving treatment with prednisone or prednisolone (for example, abnormal behavior, aggression or irritability)? ❑ Yes ❑ No

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9. Did the psychiatric or behavioral issues persist beyond the first 6 weeks of treatment with prednisone or prednisolone? ***ACTION REQUIRED: If Yes, attach chart documentation of persistent psychiatric or behavioral issues with prednisone or prednisolone treatment.*** ❑ Yes ❑ No

10. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing showing a mutation in the DMD gene? ***ACTION REQUIRED: If Yes, attach a copy of the laboratory report confirming DMD gene mutation and skip to #12.*** ❑ Yes ❑ No

11. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by a muscle biopsy demonstrating absent dystrophin? ***ACTION REQUIRED: If Yes, attach a copy of the patient's medical record confirming a muscle biopsy demonstrated absent dystrophin.*** ❑ Yes ❑ No

12. Has the patient tried treatment with prednisone or prednisolone? ❑ Yes ❑ No

13. Is this request for continuation of therapy with the requested medication?
❑ Yes ❑ No *If No, no further questions.*

14. Is the patient receiving a clinical benefit from the requested medication therapy, such as improvement or stabilization of muscle strength or pulmonary function? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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