BlueCross BlueShield
Federal Employee Program

EMFLAZA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Emflaza (deflazacort)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑ Brand ❑ Generic

1. Does the patient have a diagnosis of Duchenne muscular dystrophy (DMD)? ❑Yes ❑No

2. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

3. Does the patient have a history of hepatitis B (HBV) infection? ❑Yes* ❑No
   If YES, will the prescriber agree to monitor for HBV reactivation? ❑Yes ❑No

4. Will the patient be given live vaccines while on Emflaza? ❑Yes ❑No

5. Has the patient been on Emflaza continuously for the last **4 months**, excluding samples? ***Please select answer below:***

   ❑**NO** – this is **INITIATION** of therapy, please answer the following questions:
   - a. Does the patient have a genetic confirmation of DMD? ❑Yes ❑No
   - b. Prior to initiating treatment, is the serum creatinine kinase activity at least 10 times the upper limit of normal (ULN)? ❑Yes ❑No
   - c. Has a baseline motor milestone score been obtained from one of the following assessments: 6-minute walk test (6MWT), North Star Ambulatory Assessment (NSAA), or Motor Function Measure (MFM)? ❑Yes ❑No
   - d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of prednisone? ❑Yes ❑No

   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   - a. Has there been stabilization or an improvement from the baseline motor milestone score from one of the following assessments: 6-minute walk test (6MWT), North Star Ambulatory Assessment (NSAA), or Motor Function Measure (MFM)? ❑Yes ❑No