Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Duchenne Muscular Dystrophy: Emflaza

Member Information

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

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Emflaza** 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
   Reauthorization Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

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? (Documentation required) ☐ **Yes** ☐ **No**
   Answer questions **a.** and **b.** when the response to question 3 is **'Yes'.**
   a. Has the member had an inadequate treatment response to prednisone? **If yes, documentation is required.** ☐ **Yes** ☐ **No**
   b. 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? ☐ **Yes** ☐ **No (If yes, documentation required.)**
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.
   ☐ 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.

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Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277