Corticosteroids – Deflazacort (Emflaza)

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response [e.g. stabilization of muscle strength or pulmonary function]? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Duchenne muscular dystrophy confirmed by genetic testing
   ☐ Other. Specify: _________________

3. Does patient have a history of failure as stated below, contraindication, or intolerance to a 6-month trial of prednisone within the past 12 months defined by one of the following (check all that apply):
   ☐ Increase of 10 weight-for-age percentiles within the past 12 months
   ☐ Weight gain resulting in greater than or equal to the 85th weight-for-age percentile within the past 12 months
   ☐ Severe psychiatric adverse effects
   ☐ Other, contraindication or intolerance. Describe: _______________________

4. Was this prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

The following are required with this request:

- Chart notes
- Genetic testing confirming diagnosis

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)