UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Emflaza

Patient name:___________________________________Medicaid ID #:________________________________

Prescriber Name:___________________________Prescriber NPI#:________________________ Contact person:________________________

Prescriber Phone#:_________________Extension/Option:_________________ Fax#:____________________

Pharmacy:___________________________Pharmacy Phone#:________________Pharmacy Fax #:________________________

Requested Medication:______________________________Strength:_________ Frequency:_________

All information to be legible, complete and correct or form will be returned

________________________

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

• Laboratory confirmation of DMD diagnosis by genetic testing; AND
• Patient is male and 5 years of age or older; AND
• Patient has tried prednisone for 3 months and experienced unmanageable side effects:
  – Weight gain OR
  – Psychiatric or behavioral issues; AND
• Prescribed by neurologist.
• Initial Authorization for up to 6 months

REAUTHORIZATION CRITERIA:

• Chart notes demonstrating positive response to therapy.
• Reauthorization every 12 months

09/13/2017

https://medicaid.utah.gov/pharmacy/