# Corticosteroids – Deflazacort (Emflaza)

Please provide the information below, print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

**Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3**

*Apple Health Preferred Drug List*: *https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

| | | | |
|---|---|---|---|
| Date of request: | | | |
| Patient | Date of birth | Molina 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 |