MOLINA HEALTHCARE
Iowa Health Link Iowa HHS Hawki Iowa HHS

**Request for Prior Authorization**

# Oral Glucocorticoids for Duchenne muscular dystrophy

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**FAX Completed Form To**
1 (877) 733-3195
**Provider Help Desk**
1 (844) 236-1464

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |

**Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.**

| Pharmacy NPI | Pharmacy fax | NDC |
|---|---|---|

**Prior authorization (PA) is required for oral glucocorticoids for Duchenne muscular dystrophy (DMD). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of DMD with documented mutation of the dystrophin gene; and 2) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3) Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and 4) Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.**

**Preferred**

☐ Emflaza

**Non-Preferred**

☐ Agamree ☐ Deflazacort

| Strength | Usage Instructions | Quantity | Day's Supply |
|---|---|---|---|
| | | | |

Diagnosis: _____

Documented mutation of the dystrophin gene? ☐ Yes (attach documentation) ☐ No

Patient's current weight (kg): _____

**Does prescriber specialize in treatment of DMD?**

☐ Yes ☐ No If no, note consultation with physician who specializes in treatment of DMD:

Consultation date: _____ Physician name & phone: _____

**Prednisone Trial:** Drug name/dose: _____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Medical or contraindication reason to override trial requirements: _____

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|
| | |

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*