Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Emflaza (Deflazacort) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Emflaza (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)		
EMFLAZA 6 MG TABLET	EMFLAZA 18 MG TABLET	EMFLAZA 30 MG TABLET
EMFLAZA 36 MG TABLET	EMFLAZA 22.75 MG/ML ORAL SUSP	

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the medication being prescribed by, or in consultation with, a neurologist? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, go to question denied.

3. Does the patient have a claim for a moderate or strong CYP3A4 inducers in the last 90 days? Y N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Is this request for continuation of therapy? Y N
   If the answer to this question is yes, go to question 5.

If the answer to this question is no, go to question 6.

5. Does the physician state that the patient continues to have a positive response to therapy? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

6. Is the patient greater than or equal to 2 years of age? Y N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, go to denied.

7. Does the patient have a diagnosis of Duchenne muscular dystrophy (DMD) in the last 730 days? Y N
   If the answer to this question is yes, go to question 8.
   If the answer to this question is no, denied.

8. Has the patient tried prednisone for greater than or equal to 6 months, AND have one of the following adverse events as a result of prednisone use? A) Cushingoid appearance, B) Central (truncal) obesity, C) Undesirable weight gain (defined as greater than or equal to 10% body weight gain over a 6 months period), OR D) Diabetes and/or hypertension that is difficult to manage according to the prescribing physician. Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, go to question 9.

9. Has the patient experienced a severe behavioral adverse event while on prednisone therapy that has or will require a prednisone dose reduction? Y N
   If the answer to this question is yes, go to question 10.
   If the answer to this question is no, denied.

10. Is this request for a non-preferred drug? Y N
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 365 days.

11. Has the patient failed a 10-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
    If the answer to this question is yes, approved for 365 days.
    If the answer to this question is no, go to question 12.

12. Is there a documented allergy or contraindication to preferred agents in this class? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, go to question 13.

13. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
    If the answer to this question is yes, approved 365 days.
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date