OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Emflaza® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Duchenne muscular dystrophy (DMD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient received genetic testing for a mutation of the dystrophin gene? ❑ **Yes** ❑ **No**

Is there documentation of a confirmed mutation of the dystrophin gene? ❑ **Yes** ❑ **No**

Is there confirmed absence of the dystrophin protein in muscle biopsy? ❑ **Yes** ❑ **No**

Is Emflaza prescribed by or in consultation with a neurologist who has experience treating children? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure or intolerance to prednisone or prednisolone given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend? ❑ **Yes** ❑ **No**

Will the dose exceed 0.9 milligrams per kilogram of body weight once daily? ❑ **Yes** ❑ **No**

Reauthorization:

Has the patient experienced a benefit from therapy (e.g., improvement or preservation of muscle strength)? ❑ **Yes** ❑ **No**

Will the dose exceed 0.9 milligrams per kilogram of body weight once daily? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.