



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Deflazacort
Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the requested medication prescribed by or in consultation with a physician who specializes in the treatment of Duchenne muscular dystrophy (DMD)?

☐ Yes

☐ No

Q2. Is the request for initial therapy? If YES, go to 3. If NO, go to 6.

☐ Yes

☐ No

Q3. Does the patient have a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by one of the following?

A) Genetic testing demonstrating a mutation in the DMD gene

B) Muscle biopsy demonstrating absent dystrophin

☐ Yes

☐ No

Q4. Is the patient 2 years of age or older for brand Emflaza or 5 years of age or older for deflazacort (generic)?

☐ Yes

☐ No



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Patient Name:

Prescriber Name:

Q5. Has the patient tried prednisone or prednisolone and experienced unmanageable and clinically significant weight gain/obesity or psychiatric/behavioral issues (e.g., abnormal behavior, aggression, irritability)? Please attach documentation.

For weight gain/obesity: body mass index is in the overweight or obese category while receiving treatment with prednisone or prednisolone

☐ Yes

☐ No

Q6. For reauthorization, does the member meet all initial authorization criteria?

☐ Yes

☐ No

Q7. Is the patient receiving a clinical benefit from Emflaza therapy, such as improvement or stabilization of muscle strength or pulmonary function?

☐ Yes

☐ No

Q8. Additional Information:

Prescriber Signature

Date

v2025