Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health
Deflazacort (Emflaza) – Medical Necessity Request
*****Initial requests*****

Diagnosis Information:

1. What is the diagnosis?
    a. □ Duchenne Muscular Dystrophy (DMD)
        *****Please send a copy of the genetic testing*****
    b. □ Other: _____

Dosing Information:

1. What is the dose? _____ mg/kg/day OR _____ mg/day

2. What is the member's current weight? ____ lbs or ____ kg
    a. Date Taken: _____ (note, date must be from past 30 days)

Previous Therapy Information:

1. Has the member tried prednisone?
    a. □ Yes
        i. What dose of prednisone was tried? _____ mg/day.
        ii. What was the member's weight while on prednisone?: _____ lbs or _____kg
            1. Date Taken: _____

        iii. For how long was prednisone tried (note the dates tried)?
        _____
            a. Please let us know the specific reason(s) why the member cannot continue using prednisone :
            *****Documentation (such as chart notes) must be provided*****
            _____
            _____
            _____
            _____
    b. □ No
        i. Can the member try prednisone at the optimal dose of 0.75mg/kg/day?
            1. □ Yes (please call in a prescription to the pharmacy)
            2. □ No
                a. Reason why: _____

Prescriber Information:

1. What is the prescriber's specialty? _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Deflazacort (Emflaza) – Medical Necessity Request

******Subsequent requests******

Current Therapy Information:

1. Has the member experienced symptomatic improvement (or has not had a decline) while on Emflaza?
    a. □ Yes
    b. □ No
        i. Please let us know why the member is still on Emflaza:
        _____
        _____

Dosing Information:

1. What is the member's current weight?: ____ lbs or ____ kg
    a. Date Taken: _____ (note, date must be from past 30 days)

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**