Jefferson Health Plans

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: □ 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 this an initial or continuation request?

☐ Initial - Go to 2 ☐ Continuation - Go to 5

Q2. 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

Q3. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q4. 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):
A) For weight gain/obesity: body mass index is in the overweight or obese category while receiving treatment with prednisone or prednisolone
B) For psychiatric/behavioral issues: psychiatric/behavioral issues persisted beyond the first 6

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weeks of treatment with prednisone or prednisolone?
Please attach documentation.

☐ Yes ☐ No

Q5. For reauthorization, is the patient receiving a clinical benefit from Emflaza therapy, such as improvement or stabilization of muscle strength or pulmonary function?

☐ Yes ☐ No

Q6. Additional Information:

_____ _____

Prescriber Signature Date

v2025