

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.  
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**  
**Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**
**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of Duchenne muscular dystrophy?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication, or intolerance to prednisone or prednisolone for the treatment of Duchenne muscular dystrophy?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has Emflaza been prescribed by or in consultation with a neurologist?</b>

**CONTINUATION OF THERAPY**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there physician attestation that the patient has had a positive clinical response to Emflaza therapy?</b>
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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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