

## NC Pharmacy Prior Approval Request for Emlaza

### Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____
5. Beneficiary Gender: _____	

### Prescriber Information

6. Prescribing Provider NPI #: _____	
7. Requester Contact Information - Name: _____	Phone #: _____ Ext. _____

### Drug Information

8. Drug Name: _____	9. Strength: _____	10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request- <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days		
Reauthorization Request- <input type="checkbox"/> up to 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days <input type="checkbox"/> 180 Days <input type="checkbox"/> 365 Days		

### Clinical Information

<b>Initial Authorization Request:</b>	
1. Is the beneficiary age 2 or older? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does the beneficiary have a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic testing (Documentation required)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the beneficiary tried prednisone? <input type="checkbox"/> Yes <input type="checkbox"/> No Answer questions 3a and 3b when the response to question 3 is 'Yes'.	
3a. Has the beneficiary had an inadequate treatment response to prednisone? If yes, documentation is required. <input type="checkbox"/> Yes <input type="checkbox"/> No	
3b. Has the beneficiary experienced unmanageable and clinically significant side effects such as significant weight gain/obesity, persistent psychiatric/behavioral issues, diabetes, hypertension, or Cushingoid appearance? If yes, documentation required. <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. A baseline motor milestone assessment is required. Please select all that apply and submit documentation:	
<input type="checkbox"/> 6-minute walk test (6MWT)	
<input type="checkbox"/> North Star Ambulatory Assessment (NSAA)	
<input type="checkbox"/> Motor Function Measure (MFM)	
<input type="checkbox"/> Hammersmith Functional Motor Scale (HFMS)	
<input type="checkbox"/> Other – Please Explain: _____	
<input type="checkbox"/> None of the above	
5. Is the medication prescribed by or in consultation with a neurologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Will the provider ensure that Emlaza is not being given concurrently with live vaccinations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is Emlaza dosing for Duchenne Muscular Dystrophy in accordance with the USFDA approved labeling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Reauthorization Request:</b>	
Please check all of the applicable clinical benefits the beneficiary has received from Emlaza therapy (Please submit documentation for each):	
8. A baseline motor milestone assessment is required. Please select all that apply and submit documentation. 8a. Stabilization, maintenance or improvement of muscle strength	
<input type="checkbox"/> Stabilization, maintenance or improvement of pulmonary function	
<input type="checkbox"/> Improvement in motor milestone assessment scores from baseline testing	
<input type="checkbox"/> Motor function is superior relative to that projected for the natural course of Duchenne Muscular Dystrophy	
<input type="checkbox"/> Other – Please Explain: _____	
<input type="checkbox"/> None of the above	

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.