UnitedHealthcare Community Plan

Corticosteroids – Deflazacort (Emflaza) - Washington

Prior Authorization Request Form

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):		

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/Days supply:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Clinical and Drug Specific Information

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response [e.g. stabilization of muscle strength or pulmonary function]? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Duchenne muscular dystrophy confirmed by genetic testing
   ☐ Other. Specify: ___________________

3. Does patient have a history of failure as stated below, contraindication, or intolerance to a 6-month trial of prednisone within the past 12 months defined by one of the following (check all that apply):
   ☐ Increase of 10 weight-for-age percentiles within the past 12 months
   ☐ Weight gain resulting in greater than or equal to the 85th weight-for-age percentile within the past 12 months
   ☐ Severe psychiatric adverse effects
   ☐ Other, contraindication or intolerance. Describe: __________________________

4. Was this prescribed by, or in consultation with, a neurologist? ☐ Yes ☐ No

The following are required with this request:

- Chart notes
- Genetic testing confirming diagnosis

Prescriber signature	Prescriber specialty	Date

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