Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Emflaza

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the diagnosis?
   ❑ Duchenne muscular dystrophy ❑ Other _____
2. What is the ICD-10 code? _____
3. The preferred product for your patient's health plan is prednisone. Can the patient's treatment be switched to the prednisone? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No
4. Is this request for continuation of therapy with the requested product? ❑ Yes ❑ No *If No, skip to #6*
5. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes. ❑ Yes ❑ No
6. Did the patient experience unmanageable and clinically significant weight gain or obesity while receiving treatment with the preferred product (prednisone)? ***ACTION REQUIRED: If Yes, attach chart documentation of weight gain or obesity (i.e., body mass index [BMI] or BMI percentile) while receiving treatment with prednisone.*** ❑ Yes ❑ No *If No, skip to #10*
7. What is/was the patient's age at the time of prednisone treatment? _____ years
8. *If patient is 2 years to 19 years of age,* what was the body mass index percentile while receiving treatment with prednisone? *Indicate percentile and skip to #12:* _____% *If 85th percentile or higher, complete this form in its entirety and State Step Therapy section.*
9. *If patient is 20 years of age or older,* what was the body mass index while receiving treatment with prednisone? *Indicate BMI and skip to #12:* _____ *If 25 or more, complete this form in its entirety and State Step Therapy section.*
10. Did the patient experience unmanageable and clinically significant psychiatric or behavioral issues while receiving treatment with prednisone (for example, abnormal behavior, aggression or irritability)?
    ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

11. Did the psychiatric or behavioral issues persist beyond the first 6 weeks of treatment with prednisone? ***ACTION REQUIRED: If Yes, attach chart documentation of persistent psychiatric or behavioral issues with prednisone treatment.*** ❑ Yes ❑ No *If No, complete this form in its entirety and State Step Therapy section.*
12. Was the diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing showing a mutation in the *DMD* gene? ***ACTION REQUIRED: If Yes, attach a copy of the laboratory report confirming DMD gene mutation.*** ❑ Yes ❑ No
13. Has the patient tried treatment with prednisone? ❑ Yes ❑ No
14. Is this request for continuation of therapy with Emflaza? ❑ Yes ❑ No *If No, no further questions.*
15. Is the patient receiving a clinical benefit from Emflaza therapy, such as improvement or stabilization of muscle strength or pulmonary function? ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*
4. Is the alternate drug (prednisone) FDA-approved for the medical condition being treated? ❑ Yes ❑ No *If No, no further questions.*
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*
7. Are any of the following conditions met for the alternate drug (prednisone)?
   If Yes, indicate below and no further questions.
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above, *continue to #8*
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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