

Request for Prior Authorization Oral Glucocorticoids for Duchenne muscular dystrophy

FAX Completed Form To 1 (800) 574-2515 Provider Help Desk 1 (877) 776-1567

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address	<u> </u>	
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all informa	ation above. It must be legible, correct, and co	nplete or form will be returned.
Pharmacy NPI		NDC
Payment will be considered for pa documented mutation of the dystro onset of weakness before 5 years treatment of DMD; and 5) Patient weight gain (significant weight gain on prednisone at a therapeutic dose	for oral glucocorticoids used for the treatmen atients when the following criteria are met: ophin gene; and 2) Patient is within the FDA of age; and 4) Is prescribed by or in consul has documentation of an adequate trial and defined as 1 standard deviation above basel a; and 6) Is dosed based on FDA approved dovided that use of these agents would be medical.	1) Patient has a diagnosis of DMD with labeled age; and 3) Patient experienced tation with a physician who specializes in therapy failure, intolerance, or significant ine percentile rank weight for height) while sing. The required trials may be overridden
Non-Preferred		
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

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