IOWA Health and Human Services

Request for Prior Authorization
Oral Glucocorticoids for Duchenne muscular dystrophy

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for oral glucocorticoids for Duchenne muscular dystrophy (DMD). Payment for non-preferred agents will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of DMD with documented mutation of the dystrophin gene; and 2) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and 3) Is prescribed by or in consultation with a physician who specializes in treatment of DMD; and 4) Patient has documentation of an adequate trial and therapy failure, intolerance, or significant weight gain (significant weight gain defined as 1 standard deviation above baseline percentile rank weight for height) while on prednisone at a therapeutic dose. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Emflaza

Non-Preferred

☐ Agamree ☐ Deflazacort

Strength	Usage Instructions	Quantity	Day's Supply

Diagnosis: _____

Documented mutation of the dystrophin gene? ☐ Yes (attach documentation) ☐ No

Patient's current weight (kg): _____

Does prescriber specialize in treatment of DMD?

☐ Yes ☐ No If no, note consultation with physician who specializes in treatment of DMD:

Consultation date: _____ Physician name & phone: _____

Prednisone Trial: Drug name/dose: _____

Trial start date: _____ Trial end date: _____

Reason for failure: _____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

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.*