Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Emflaza
(deflazcort)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: (*please specify name, strength, and dosing schedule)* ICD10:

☐ Emflaza 22.75 mg/mL oral suspension ☐ Emflaza 6 mg tablet ☐ Emflaza 18 mg tablet
☐ Emflaza 30 mg tablet ☐ Emflaza 36 mg tablet ☐ Other: (please specify name, strength)

Directions for use: Quantity requested: Duration of therapy:

Patient's current weight: _____ kg or lbs (circle one)

Is this for new start or continuation of therapy? ☐ new start ☐ continued therapy
(if continuation of therapy) Is there documentation that your patient is having a positive clinical response (for example: improvement or stabilization of muscle strength) from pretreatment baseline status with Emflaza? Yes ☐ No ☐
(if no) Please provide clinical support for the continued use of Emflaza.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ Duchenne muscular dystrophy (DMD) ☐ Other (please specify):

Clinical Information:
****This drug requires supportive documentation (genetic testing, biopsy reports, chart notes, etc). Supportive documentation for all answers must be attached with this request.****

Is there documentation that your patient has a variation of the dystrophin gene that can or will cause Duchenne muscular dystrophy? Please provide genetic testing results. Yes ☐ No ☐
(if no) Is there documentation that a muscle biopsy shows your patient has an absence of dystrophin protein? Please provide muscle biopsy results. Yes ☐ No ☐

Additional pertinent information: (*please include clinical reasons for drug, other alternatives tried [list all details of trial], relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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