TEXAS MEDICAID
Clinical Edit Prior Authorization
deflazacort (EMFLAZA) - Initial Requests

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to (≥) 2 years of age?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Duchenne muscular dystrophy (DMD) in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Deny)

3. Is the medication being prescribed by, or in consultation with, a neurologist? [Manual Step]

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Has the client tried prednisone for greater than or equal to (≥) 6 months **AND** have ONE (1) of the following adverse events as a result of prednisone use? [Manual Step]

   - Central (truncal) obesity
   - Cushingoid appearance
   - Diabetes and/or hypertension that is difficult to manage according to the prescribing physician
   - Undesirable weight gain (defined as greater than or equal to [≥] 10% body weight gain over a 6-month period)

   ☐ Yes (Go to #6) ☐ No (Go to #5)

5. Has the client experienced a severe behavioral adverse event while on prednisone therapy that has or will require a prednisone dose reduction? [Manual Step]

   ☐ Yes (Go to #6) ☐ No (Deny)

6. Does the client have a claim for a moderate or strong CYP3A4 inducer in the last 90 days?

   Examples include ATRIPLA, carbamazepine (EPITOL, EQUETRO, TEGRETOL), nevirapine (VIRAMUNE), phenobarbital, phenytoin (DILANTIN), pioglitazone (ACTOS), rifabutin (MYCOBUTIN), rifampin (RIFADIN), RIFATER, SUSTIVA, and XTANDI.

   ☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.