

## Emflaza<sup>™</sup> Prior Authorization Request Form

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Memb	Pro	<b>Provider Information</b> (required)					
Member Name:	Provider Name:	Provider Name:					
Insurance ID#:	NPI#:		Specialty:				
Date of Birth:	Office Phone:	Office Phone:					
Street Address:	Office Fax:	Office Fax:					
City:	State:	Zip:	Office Street Add	Office Street Address:			
Phone:			City:	State:		Zip:	
Medication Information (required)							
Medication Name:			Strength:	Strength:		Dosage Form:	
Check if requesting	Directions for Us	Directions for Use:					
Check if request is							
Clinical Information (required)							
Select the diagno	osis below:						
Duchenne mus	cular dystroph	/					
Other diagnosi	ICD-10 Code	_ ICD-10 Code(s):					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-855-401-4262. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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