



# EMFLAZA<sup>®</sup> (deflazacort) Prescription Start Form

**TO BE COMPLETED BY PATIENT/CAREGIVER**

**Phone:** 1-844-4PTCCARES (1-844-478-2227)      **Fax:** 1-844-322-9980

- Step 1:** Please complete all fields on this form including the prescriptions to prevent delays in processing.
- Step 2:** If able, obtain patient's signature for the HIPAA authorization and PTC Cares<sup>™</sup> program.
- Step 3:** Fax this form, along with copies of both sides of insurance and prescription benefit cards, to PTC Cares.

## PATIENT INFORMATION

**Patient First Name:** \_\_\_\_\_ **Patient Last Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Guardian/Caregiver's Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Apt:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**Gender:**     Male             Female            **Email Address:** \_\_\_\_\_

**Ok to leave message:**     Yes             No            **Preferred Contact Number:**     Home     Mobile

**Best time to reach me:**     Morning     Afternoon     Evening

## INSURANCE INFORMATION

	Primary Insurance	Secondary Insurance
<b>Drug Insurance</b>		
<b>Phone Number</b>		
<b>Policy Number</b>		
<b>Group Number</b>		
<b>Policyholder Name</b>		
<b>Rx Member ID</b>		
<b>Rx BIN (if applicable)</b>		
<b>Rx Group ID</b>		

- Patient has no insurance.
- Send copy front/back of prescription, medical, secondary insurance cards.

### Patient Authorization for 1) Disclosure of Information 2) Program Participation 3) Marketing Materials

I have read and agree to the following HIPAA Authorization to share health information and participate in the PTC Cares<sup>™</sup> program. I authorize my healthcare providers and health plans to disclose personal and medical information related to my use or potential use of EMFLAZA<sup>®</sup> (deflazacort) to PTC Therapeutics, Inc. and its agents and contractors including, but not limited to, PTC's specialty pharmacy partners and authorize PTC Therapeutics, its agents, and my pharmacies to use such information to: 1) determine benefit eligibility; 2) communicate with my healthcare providers and health plans about benefit, coverage and medical care; 3) provide me with support services for EMFLAZA<sup>®</sup> (deflazacort); 4) contact me and leave messages about EMFLAZA<sup>®</sup> (deflazacort); 5) provide me with information or materials related to EMFLAZA<sup>®</sup> (deflazacort) or my relevant medical conditions; 6) contact me about the PTC Cares<sup>™</sup> program, which may include patient services such as education, training, nurse and pharmacy support; and 7) I understand that my pharmacy may receive remuneration in exchange for sharing and using my information pursuant to this authorization. PTC Therapeutics will maintain the confidentiality of my personal and medical information in accordance with its privacy policy and will use this information only for the purposes described above or as permitted by law. However, I understand that personal and medical information disclosed to PTC Therapeutics pursuant to this authorization may be subject to re-disclosure, and privacy laws may no longer restrict its use or disclosure. I further understand that I may refuse to sign this authorization and that my refusal to sign this authorization will have no impact on my eligibility to receive health plan benefits or treatments from my healthcare providers, but I will not have access to support services from the PTC Cares<sup>™</sup> program. I understand that I have the right to revoke this authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by submitting a written notice to PTC Therapeutics via fax to 1-908-222-7231 or by mail to PTC Therapeutics, Inc., Attention: Compliance Officer, 100 Corporate Court, South Plainfield, NJ, 07080-2449. I understand that after I have revoked my authorization, PTC Therapeutics will stop using the personal and medical information already obtained for the purposes described above. I am entitled to a copy of this authorization, which expires 10 years from the date it is signed by me (unless earlier termination is required by applicable state law). The personal, insurance and health information I have provided on this form is complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting PTC Cares<sup>™</sup> at 1-844-478-2227.

Patient/Guardian Signature: **X** \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_




**TO BE COMPLETED BY HEALTHCARE PROVIDER**

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**CLINICAL INFORMATION**

Primary Diagnosis: \_\_\_\_\_ Primary ICD-10: \_\_\_\_\_

 Is patient currently on deflazacort?  Yes **Milligrams per day:** \_\_\_\_\_ **Start date:** \_\_\_\_\_  Not on deflazacort

 Current weight: \_\_\_\_\_  lbs.  kg. **Date weight obtained:** \_\_\_\_\_ **Date of last clinic visit:** \_\_\_\_\_

Other medications tried: \_\_\_\_\_

 Corticosteroid use:  Yes  No If yes, name of corticosteroid: \_\_\_\_\_

Dates of corticosteroid use: \_\_\_\_\_

Mutation type (attach genetic test): \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber First Name: \_\_\_\_\_ Prescriber Last Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

 Best time to contact:  Morning  Afternoon **NPI#:** \_\_\_\_\_

Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**PRESCRIPTION INFORMATION**
**EMFLAZA<sup>®</sup> (deflazacort) (Recommended dose: 0.9 mg/kg/day)**
**COMPLETE PRESCRIPTION**

For prescription fulfillment by pharmacy after benefit investigation\*

**Check tablets or suspension**

- 
- EMFLAZA (deflazacort) Tablets
- 
- 
- EMFLAZA (deflazacort) Oral Suspension (22.75 mg/mL)

**Check one SIG (directions for use) box below AND complete quantity needed for day supply and refills**

- 
- SIG: Take 0.9 mg/kg orally once a day
- 
- 
- SIG: Take \_\_\_\_\_ mg orally once a day
- 
- 
- SIG: \_\_\_\_\_

Dispense quantity needed for \_\_\_\_\_ Days with \_\_\_\_\_ Refills

**Prescriber's Signature: Physician attests this is his/her signature. No Stamps.**

\_\_\_\_\_ Date \_\_\_\_\_

Signature Dispense As Written

\_\_\_\_\_ Date \_\_\_\_\_

Substitution Permitted

 \_\_\_\_\_ Date \_\_\_\_\_

Supervising Physician Signature (where required)

Non-Commercial Supply: For prescription fulfillment by pharmacy while benefits investigation is ongoing\*

**Check tablets or suspension**

- 
- EMFLAZA (deflazacort) Tablets
- 
- 
- EMFLAZA (deflazacort) Oral Suspension (22.75 mg/mL)

**Check one SIG (directions for use) box below AND complete quantity needed for day supply and refills**

- 
- SIG: Take 0.9 mg/kg orally once a day
- 
- 
- SIG: Take \_\_\_\_\_ mg orally once a day
- 
- 
- SIG: \_\_\_\_\_

Dispense quantity needed for \_\_\_\_\_ Days with \_\_\_\_\_ Refills

**Prescriber's Signature: Physician attests this is his/her signature. No Stamps.**

\_\_\_\_\_ Date \_\_\_\_\_

Signature Dispense As Written

\_\_\_\_\_ Date \_\_\_\_\_

Substitution Permitted

 \_\_\_\_\_ Date \_\_\_\_\_

Supervising Physician Signature (where required)

**\*NY Prescribers: must also submit an electronic prescription.**

I certify that I have prescribed EMFLAZA<sup>®</sup> (deflazacort) as described above based on my professional judgment of medical necessity. I authorize PTC Therapeutics, Inc., its affiliates, agents, and contractors (collectively, PTC) to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan. I authorize the release of medical and/or other patient information relating to EMFLAZA therapy to agents of PTC Therapeutics, Inc., and service providers (including, but not limited to EMFLAZA-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize PTC's specialty pharmacy partners to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

 Prescriber Authorization Signature:  \_\_\_\_\_ Date: \_\_\_\_\_

 Please see [www.EMFLAZA.com](http://www.EMFLAZA.com) for full Prescribing Information.