PTC Cares™

EMFLAZA® (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 TWO prescriptions to prevent delays in processing.
Step 2: If able, obtain patient's signature for the HIPAA authorization and PTC *Cares* 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
Drug Insurance		
Phone Number		
Policy Number		
Group Number		
Policyholder Name		
Rx Member ID		
Rx BIN (if applicable)		
Rx Group ID		

☐ Patient has no insurance.

☐ Send copy front/back of prescription, medical, secondary insurance cards.

Patient HIPAA Authorization and Program Participation

I have read and agree to the following HIPAA Authorization to share health information and participate in the PTC *Cares*™ program. I authorize my healthcare providers and health plans to disclose personal and medical information related to my use or potential use of EMFLAZA® (deflazacort) to PTC Therapeutics, Inc. and its agents and contractors including, but not limited to, US Bioservices specialty pharmacy and Lash and authorize PTC Therapeutics and its agents 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® (deflazacort); 4) contact me and leave messages about EMFLAZA® (deflazacort); 5) provide me with information or materials related to EMFLAZA® (deflazacort) or my relevant medical conditions; and 6) contact me about the PTC *Cares*™ program, which may include patient services such as education, training, nurse and pharmacy support. 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*™ 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*™ at 1-844-478-2227.

Patient/Guardian Signature: **X** _____

Relationship: _____ Date: _____

PTC Cares™

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

Allergies: _____ Current weight: _____ ☐ lbs. ☐ kg. Date weight obtained: _____

Other medications tried: _____

Corticosteroid use: ☐ Yes ☐ No If yes, name of corticosteroid: _____

Mutation type: _____

PRESCRIBER INFORMATION

Prescriber First Name: _____ Prescriber Last Name: _____

Clinic Name: _____

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

Best time to contact: ☐ Morning ☐ Afternoon NPI#: _____ DEA#: _____

Office Contact: _____ Phone: _____

PRESCRIPTION INFORMATION

EMFLAZA® (deflazacort) (Recommended dose: 0.9 mg/kg/day)
COMPLETE BOTH PRESCRIPTIONS

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

X _____ Date _____
Supervising Physician Signature (where required)

Bridge 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
☐ SIG: Take 0.9 mg/kg orally once a day
☐ SIG: Take ____ mg orally once a day
☐ SIG: _____
☐ No Bridge Supply Requested
Refills as follows:
• 30 days 1st fill • 30 days 2nd fill up to 180 days

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

_____ Date _____
Signature Dispense As Written

_____ Date _____
Substitution Permitted

X _____ Date _____
Supervising Physician Signature (where required)

*NY Prescribers: must also submit an electronic prescription.

I certify that I have prescribed EMFLAZA® (deflazacort) as described above based on my professional judgment of medical necessity. 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 US Bioservices 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: **X** _____ Date: _____

Please see www.EMFLAZA.com for full Prescribing Information.

Emflaza®
(deflazacort)
6 mg | 18 mg | 30 mg | 36 mg tablets
22.75 mg/mL oral suspension