Orsini Specialty Pharmacy

**Fax:** 877.765.6254 **Phone:** 800.605.1524

# EMFLAZA® PATIENT ENROLLMENT

(deflazacort)

## 1 PATIENT INFORMATION

*(Please complete the following information)*

☐ **Please attach demographic information**

Patient Name (First, MI, Last): _____ DOB: _____ Gender: ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip: _____

Patient Phone Number: _____

Parent/Caregiver Name (First, MI, Last): _____ Parent/Caregiver Phone Number: _____

## 2 INSURANCE INFORMATION

☒ **Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.**

**Primary Insurance Name:** _____

Primary Insurance ID: _____

Insurance Phone Number: _____

Policyholder Name: _____

**Secondary Insurance Name:** _____

Primary Insurance ID: _____

Insurance Phone Number: _____

Policyholder Name: _____

## 3 CLINICAL INFORMATION

☒ **Please fax clinical documentation to pharmacy along with referral form.**

ICD-10 Diagnosis Code: ☐ G71.01 Duchenne Muscular Dystrophy ☐ Other ICD-10 Code: _____

◯ NKDA ◯ Drug Allergies _____

Patient Weight: _____ ◯ lb ◯ kg Date Weight Obtained: _____ Date of Last Clinic Visit: _____

## 4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

## 5 PRESCRIPTION INFORMATION

**Emflaza (deflazacort) (Recommended dose: 0.9 mg/kg/day)** ◯ May Substitute ◯ Dispense as Written

**Dosage form: Check one option**

◯ EMFLAZA (deflazacort) Tablets (6mg, 18mg, 30mg, 36mg) ◯ EMFLAZA (deflazacort) Oral Suspension (22.75mg/mL)

**Directions for use: Check one option**

◯ Take 0.9 mg/kg orally once daily

◯ Take _____ mg orally once daily

◯ Other Directions _____

**Dispense:** 30 Day Supply **Refills:** 1 year

Physician's Signature _____ Date of Signature _____