TO BE COMPLETED BY PATIENT/CAREGIVER

EMFLAZA® (deflazacort) Prescription Start Form

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*™ 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.

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

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

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

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® (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.

X _____ Date _____
Dispense as Written Signature

X _____ Date _____
Substitution Permitted

X _____ 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.

X _____ Date _____
Dispense as Written Signature

X _____ 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 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: **X** _____ Date: _____

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

Patient Direction and Consent for PTC *Cares*™ Program Participation

I hereby direct my healthcare providers and health plans to disclose my protected health information related to my health conditions, diagnosis, treatment, and use or potential use of EMFLAZA® (deflazacort) and any inferences that may be drawn from this information (my "PHI") to PTC Therapeutics US, Inc. and its affiliates, agents and contractors (together "PTC") including, but not limited to, PTC's specialty pharmacy partners. This direction for disclosure of my PHI as set forth in this form is made pursuant to 45 CFR § 164.524.

I understand and agree that PTC and my pharmacies or designated treatment center may use and process my PHI—which when managed by PTC may be considered to be Sensitive Data and/or Consumer Health Data under the laws of some states—to enroll me in the PTC *Cares*™ Program, which includes the following services, which I've requested (the "PTC *Cares*™ Program" or "Program"): 1) determining my benefit eligibility for EMFLAZA® (deflazacort); 2) communicating with my healthcare providers and health plans about benefit, coverage and medical care; 3) providing me with support services for EMFLAZA® (deflazacort); and 4) to contact me, leave me messages, and/or provide me with information or materials related to EMFLAZA® (deflazacort), my relevant medical conditions, and/or the Program, which may include patient services such as education, training, nurse, and pharmacy support. To the extent permitted by local regulations, the Program may be utilizing artificial intelligence (AI) to increase quality, to expedite the review process, and to improve user experience. All AI generated content has been reviewed and approved by the Program team.

I further understand that I may decide not to issue this Direction or sign this Consent and that my refusal 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 may terminate this Direction to my healthcare providers to disclose my PHI and/or revoke my Consent for the continued collection and processing of my Sensitive Data/Consumer Health Data in connection with the Program, at any time by submitting a written notice to PTC Therapeutics via fax to 1-908-222-7231 or by mail to PTC Therapeutics. Attention: Compliance Officer, PTC Therapeutics, 500 Warren Corporate Center Drive, Warren, NJ 07059. I understand that my termination/revocation will not have a retroactive effect on any collection or processing activities which PTC took before it received my termination/revocation and that my termination/revocation will mean that I will no longer receive support services from the Program. This Direction and Consent will expire 10 years from the date it is signed by me. I understand that my pharmacy may receive remuneration in exchange for sharing and using my information pursuant to this Direction and Consent. I understand I can access PTC's Privacy Statement and Consumer Health Data Statement at PTCBio.com, which also includes a description of my privacy rights. California residents can go here. The personal, insurance and information I have provided on this form are 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: _____

I understand that my act of providing the information and submitting this form is my electronic signature for this request.

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