

PHARMACY POLICY STATEMENT Kentucky Medicaid	
DRUG NAME	Emflaza (deflazacort)
BILLING CODE	Must use valid NDC code
BENEFIT TYPE	Pharmacy
SITE OF SERVICE ALLOWED	Home
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) Alternative preferred product includes Prednisone QUANTITY LIMIT – 6 mg tablets - 60 per 30 days 18 mg tablets - 30 per 30 days 30 mg tablets - 90 per 30 days 36 mg tablets - 90 per 30 days
LIST OF DIAGNOSES CONSIDERED <b>NOT</b> MEDICALLY NECESSARY	<a href="#">Click Here</a>

Emflaza (deflazacort) is a **non-preferred** product and will only be considered for coverage under the **pharmacy** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

### DUCHENNE MUSCULAR DYSTROPHY (DMD)

For **initial** authorization:

1. Member must be 5 years of age or older; AND
2. Member has documented onset of weakness before 5 years of age; AND
3. Member has documented serum creatinine kinase activity at least 10 times the upper limit of normal (ULN) at some stage in their illness; AND
4. Medication is prescribed by or in consultation with a physician who specializes in the treatment of DMD and/or neuromuscular disorders; AND
5. Member has documented trial and failure of prednisone for at least 6 months; AND
6. Member has documented baseline of Medical Research Council (MRC) 11-point scale score for Muscle Strength.
7. **Dosage allowed:** 0.9 mg/kg/day once daily.

***If member meets all the requirements listed above, the medication will be approved for 3 months.***

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Member has documented improvement of Medical Research Council (MRC) for Muscle Strength score.

***If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.***

CareSource considers Emflaza (deflazacort) not medically necessary for the treatment of the diseases that are not listed in this document.



DATE	ACTION/DESCRIPTION
05/15/2017	New policy for Emflaza created.

References:

1. Emflaza [package insert]. Northbrook, IL; Marathon Pharmaceuticals, LLC: February, 2017. Accessed on April 24, 2017.

Effective date: 05/15/2017

Revised date: 05/15/2017