Humana.

CareSource™

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 **NOT** MEDICALLY NECESSARY	Click Here

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 2 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 30 days; 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.
07/25/2019	Age coverage expanded from 5 years of age and older to 2 years of age and older.

References:

1. Emflaza [package insert]. Northbrook, IL; Marathon Pharmaceuticals, LLC: June, 2019.

Effective date: 09/26/2019
Revised date: 07/25/2019