EMFLAZA WEST VIRGINIA MEDICAID TESTIMONY

Duchenne muscular dystrophy (DMD) is a rapidly progressive and severely debilitating neuromuscular disorder affecting 1 in every 3,600-6,000 live male births.[1-3] Without treatment, the mean life expectancy is around 19 years.[1,4] DMD is marked by rapidly progressive deteriorating muscle tissue caused by mutations in the X-linked recessive DMD gene that result in a lack of functional dystrophin. Without this structural protein, muscle fibers are damaged, and over time, patients' muscles are replaced with fibrofatty connective tissue. This progressive muscle degeneration leads to eventual loss of ambulation in most boys before theirteens.[1,3,4] There are currently no cures for DMD[5]. Although management has progressed by extending functionality and lifespan,there remains significant need for an effective therapy.[1,5]

Patients with DMD may display recognizable signs and symptoms as early as 1.5 years of age[6]. As the disease progresses even further, they will have bone, pulmonary and cardiovascular complications. Without treatment and proper management, they may die in their late teens.[1]

Corticosteroids (CS) are considered standard of care and the only treatment that has been shown to slow the decline in muscle strength and function in DMD[7,8]. Corticosteroid therapy allows patients to remain ambulatory and retain upper limb function longer, as well as reducing the risk of scoliosis, helping to stabilize pulmonary function, and potentially improving cardiac function. In addition, recent studies confirm the benefits of starting treatment in younger children, before significant physical decline is observed and slows progression of disease and may extend life.[7] Even after the loss of ambulation, ongoing corticosteroid therapy is important to help maintain functional independence by extending upper limb function and preserving muscle.[7,8]

EMFLAZA® (deflazacort) was approved in February 2017 and became the first and only FDA approved corticosteroid for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older regardless of mutation or ambulation status.[9] EMFLAZA has been shown to preserve muscle strength and improve motor function while delaying disease progression and extending survival over 5-15 years of treatment as supported in the 2016 AAN Guidelines.[10] In the Duchenne Connect Registry, it was also shown that deflazacort delayed time to wheelchair milestone as compared to prednisone.[11]

Since FDA approval, there have been published data to support the effectiveness of deflazacort in DMD. Additionally, a labelling supplement to expand the indication to subjects 2 years of age and older was approved on June 7, 2019.

Emerging research from the Collaborative Trajectory Analysis Project (cTAP), the long-term use of daily deflazacort resulted in statistically significant benefits in delaying loss of ambulation (LOA), forestalling the need to correct scoliosis by delaying its onset as compared to daily prednisone[12]. Lung function as measured by FVC% predicted and other functional outcomes also showed statistically significant benefit for deflazacort over prednisone[12]. A more recent study described the reasons for switching from prednisone/prednisolone to deflazacort in a broadly representative sample of real-world clinical practices for patients with dystrophinopathies (DMD and Becker muscular dystrophy [BMD]) in the US. The primary reasons physicians listed for switching from prednisone to deflazacort were "desire to slow disease progression" (DMD: 83% and BMD: 79% of patients) and "tolerability issues" (DMD: 67% and BMD 47%).[13]

The Cooperative International Neuromuscular Research Group (CINRG) study published in Lancet in November 2017 is one of the largest prospective natural history studies in DMD across six countries; it is a ten-year study of >440 patients. The data compared age at loss of key functional milestones for deflazacort versus prednisone/ prednisolone, which tended to be more delayed in the deflazacort-treated patients. Significant values were reported with EMFLAZA extending these milestones for age at loss of ability to stand from supine by 2.3 years (p=0.0114), age at loss of ambulation by 2.8 years (p=0.0102), and age at loss of hand to mouth function by 2.3 years with retained hand function (p=0.0110). The most common side effects in all glucocorticoid treated patients were weight gain, Cushingoid features, behavior changes, growth delay, fractures, cataracts, and skin changes.[8]

In July 2019, ICER (Institute for Clinical and Economic Review) released an Evidence Report on the effectiveness and value of deflazacort, eteplirsen, and golodirsen for DMD. The Institute evaluated evidence and concluded with a majority (10-7 vote) of the ICER committee voted Deflazacort was superior to prednisone.[15]

West Virginia Medicaid's current EMFLAZA prior authorization criteria requires a child to 'step through' prednisone, a product that is not FDA approved, shows less long-term effectiveness than EMFLAZA[8], and often has significant adverse events. The emerging data and numerous other resources continue to demonstrate the superiority of EMFLAZA in treating patients with DMD and how deflazacort treatment significantly improved muscle strength, pulmonary function, and was more effective in extending motor function and survival vs prednisone or prednisolone. DMD patients lose muscle every day and it cannot be regained once it is lost. However, the loss can be slowed with the use of EMFLAZA.

Recommendations:

- We ask that West Virginia Medicaid remove the requirement to fail prednisone / prednisolone before granting accessing EMFLAZA. Our recommendation would maintain coverage of prednisone / prednisolone but allow physicians and patients to use EMFLAZA as a first line therapy if they deem it is most appropriate..

- If removing the step edit through prednisone is not possible, removing the “AND” following requirement 3 of the West Virginia EMFLAZA policy and replacing it with an “OR” could be acceptable.
- A 12-month trial of prednisone is highly restrictive and not aligned to current treatment patterns. Children will experience adverse events to chronic prednisone well before 12 months.

- We request that West Virginia Medicaid extend the prior authorization and reauthorization review period to 12 months. Until there is a cure for DMD, treatment with CS remains an appropriate course of therapy for all DMD types and should not require updated authorization more than annually.
- We request that West Virginia Medicaid remove any requirements to show disease improvement after initiating CS therapy. Unfortunately, DMD is a progressive disease, and the clinical expectation should be a steady decline in physical performance metrics including ambulation, upper extremity strength and control, scoliosis, and dilated cardiac myopathy.
- Specifically, West Virginia Medicaid requires that patients submit a baseline 6 Minute Walking Test. This requirement prohibits children who are non-ambulatory from meeting the coverage requirements for EMFLAZA. We request that this requirement be stricken from the coverage criteria.

Thank you for your consideration. If the panel requires any additional materials, including supporting publications, please let me know, and I would be happy to provide electronic copies to the group.

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