STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

EMFLAZA™ (deflazacort)

Effective 1/01/2018

Prior Authorization Request Form

EMFLAZA is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older.

Prior authorization requests for may be approved if the following criteria have been satisified:

1. Diagnosis of Duchenne muscular dystrophy (DMD); **AND**

2. Patient ≥ 5 years old; **AND**

3. Patient must have a documented history of at least 12-months continuous therapy with prednisone; **AND**

4. Documentation must be submitted indicating that the patient has experienced significant adverse effects associated with prednisone therapy. Documentation must include a detailed description of the adverse effect; as the side effect profiles are similar between deflazacort and prednisone, prior authorization shall only be granted for those patients experiencing side effects where deflazacort shows an improved profile.

5. Request must be accompanied with a baseline 6-minute walk distance (6MWD); **AND**

6. Initial authorizations shall be for 90 days. Continuation requests may be granted a 12-month approval if significant improvement is demonstrated in either the patient's adverse effect profile or 6MWD.

References

1.) Griggs RC, Miller JP, Greenberg CR, et al. Efficacy and safety of deflazacort vs prednisone and placebo for Duchenne muscular dystrophy. *Neurology*. 2016;87(20):2123-2131
2.) Lexi-Comp drug monograph for deflazacort (Reviewed 8/22/2017)
3.) Efficacy and safety of deflazacort vs prednisone and placebo for Duchenne muscular dystrophy. Neurology. 2016 Nov 15; 87(20): 2123–2131.
4.) UpToDate article: Treatment of Duchenne and Becker muscular dystrophy. Updated July 18, 2017.