UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2018 P 1218-2
Program	Prior Authorization/Notification
Medication	Emflaza™ (deflazacort)
P&T Approval Date	5/2017, 10/2018
Effective Date	2/1/2019; Oxford only: N/A

1. Background:

Emflaza™ (deflazacort) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older.[1]

2. Coverage Criteria:

A. Initial Authorization

1. **Emflaza** will be approved based on the following criterion:

   a. Diagnosis of Duchenne muscular dystrophy

   Authorization will be issued for 12 months

B. Reauthorization

1. **Emflaza** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Emflaza therapy

   Authorization will be issued for 12 months

3. Additional Clinical Rules:

- Supply limits, Medical Necessity and/or Step Therapy may be in place.

4. References:

1. Emflaza [package insert]. PTC Therapeutics Inc. June 2017.

Program	Prior Authorization/Medical Necessity - Emflaza™ (deflazacort)
Change Control	
5/2017	New program.
10/2018	Annual review. No changes to criteria. Updated reference.

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