UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2021 P 1218-5 |
| Program | Prior Authorization/Notification |
| Medication | Emflaza® (deflazacort) |
| P&T Approval Date | 5/2017, 10/2018, 10/2019, 10/2020, 10/2021 |
| Effective Date | 2/1/2022;<br>Oxford only: N/A |

**1. Background:**

Emflaza® (deflazacort) is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 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:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits, Medical Necessity and/or Step Therapy may be in place.

**4. References:**

1. Emflaza [package insert]. South Plainfield, NJ: PTC Therapeutics Inc. June 2021.

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|---|---|
| **Change Control** | |
| 5/2017 | New program. |
| 10/2018 | Annual review. No changes to criteria. Updated reference. |
| 10/2019 | Annual review. Updated background updating indication in patients 2 years and older. Updated reference. |
| 10/2020 | Annual review. No change to clinical criteria. |
| 10/2021 | Annual review with no change to clinical criteria. Reference updated. |