Pharmacy Drug Policy Checklist

POLICY NAME	Emflaza (deflazacort)	POLICY #	2607P

Criteria

Coverage Criteria

- ☐ **1.1** Diagnosis of Duchenne Muscular Dystrophy confirmed by one of the following:
  - Genetic testing documenting a mutation in the dystrophin (DMD) gene
  - Muscle biopsy documenting lack of muscle dystrophin
- ☐ **1.2** Age 2 years of age or older
- ☐ **1.3** Prescribed by or in consultation with a physician who specializes in the treatment of Duchenne Muscular Dystrophy (DMD) and/or neuromuscular disorders
- ☐ **1.4** Documented trial of prednisone for 6 months and documentation that the member experienced at least one of the following significant intolerable adverse effects (AE)
  - Cushingoid appearance
  - Central (truncal) obesity
  - Undesirable weight gain defined as a 10% of body weight gain increase over a 6-month period
  - Diabetes and/or hypertension that is difficult to manage
  - Severe behavioral adverse effects that would require a prednisone dose reduction
  - Clinically significant growth stunting as evidenced by decline in mean height percentile from baseline, decrease in growth velocity or decrease in serum bone formation biomarkers
- ☐ **1.5** Documentation of a baseline motor milestone score from one of the following assessments:
  - 6-Minute Walk Test (6MWT)
  - North Star Ambulatory Assessment (NSAA)
  - Motor Function Measure (MFM)
  - Hammersmith Functional Motor Scale (HFMS)
- ☐ **1.6** Coverage of brand Emflaza requires a documented allergic reaction to generic deflazacort