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| --- | --- | --- | --- |
| **Criteria Title** | Glucocorticoid | | |
| **Criteria Subtitle** | Emflaza (deflazacort) | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EMFLAZA | 027604 | GCNSeqNo |
| EMFLAZA | 027605 | GCNSeqNo |
| EMFLAZA | 077113 | GCNSeqNo |
| EMFLAZA | 077116 | GCNSeqNo |
| EMFLAZA | 077117 | GCNSeqNo |

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| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1001 |
| N | 1235 |
| 2 | 1001 |  | Select | Is the medication being prescribed by or in consultation with a neurologist or specialist in Duchenne Muscular Dystrophy? | Y | 1002 |
| N | 1235 |
| 3 | 1002 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 180 days to prednisone?    If yes, please submit the medication trials and dates. | Y | 1004 |
| N | 1003 |
| 4 | 1003 |  | Select and Free Text | Does the patient have a contraindication to prednisone?    If yes, please submit the medication name and reason for inability to use. | Y | 1004 |
| N | 1235 |
| 5 | 1004 |  | Select and Free Text | Has the provider submitted documentation of the patient’s weight?    If yes, please provide documentation of the patient’s weight. | Y | END (Pending Manual Review) |
| N | 1235 |
| 6 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 Days

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| --- | --- |
| **Last Approved** | 4/13/2023 |
| **Other** |  |