UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2023 P 1218-7
Program	Prior Authorization/Notification
Medication	Emflaza® (deflazacort)
P&T Approval Date	5/2017, 10/2018, 10/2019, 10/2020, 10/2021, 10/2022, 10/2023
Effective Date	1/1/2024

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]:

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

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

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.
10/2022	Annual review with no change to clinical criteria. Added state mandate footnote.
10/2023	Annual review with no changes to coverage criteria.