UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2024 P 1218-8
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, 10/2024
Effective Date	1/1/2025

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.

*Emflaza is typically excluded from coverage. Tried/Failed criteria may be in place. Please refer to plan specifics to determine exclusion status.

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]. Warren, NJ: PTC Therapeutics, Inc.; May 2024.

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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.
10/2024	Annual review with no changes to coverage criteria. Added exclusion footnote and updated reference.