PREFERRED SPECIALTY MANAGEMENT POLICY

POLICY: Muscular Dystrophy – Deflazacort Preferred Specialty Management Policy
- Emflaza® (deflazacort tablets and oral suspension – PTC Therapeutics, generics)

REVIEW DATE: 03/06/2024; selected revision 07/03/2024

OVERVIEW

Deflazacort is a corticosteroid indicated for the treatment of **Duchenne muscular dystrophy** (DMD) in patients ≥ 2 years of age.[1] The efficacy and safety of deflazacort have not been established in patients < 2 years of age.

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the standard *Muscular Dystrophy – Deflazacort Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product prior to the approval of a Non-Preferred Product. Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Muscular Dystrophy – Deflazacort Prior Authorization Policy* criteria but has not tried a Preferred Product, approval for a Preferred Product will be authorized. All approvals are provided for 1 year.

Documentation: Documentation is required for use of Emflaza tablets or oral suspension as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Automation: None.

Preferred Products:	generic deflazacort tablets
Non-Preferred Products:	Emflaza tablets, Emflaza oral suspension, generic deflazacort oral suspension

RECOMMENDED EXCEPTION CRITERIA

REFERENCES

1. Emflaza™ tablets [prescribing information]. South Plainfield, NJ: PTC Therapeutics; June 2021.