

Clinical Policy: Deflazacort (Emflaza)

Reference Number: CP.PHAR.331

Effective Date: 03/17

Last Review Date: 03/17

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for deflazacort (Emflaza™).

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that Emflaza is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Duchenne Muscular Dystrophy (must meet all):

1. Diagnosis of Duchenne muscular dystrophy (DMD) confirmed by one of the following (a or b):
 - a. Genetic testing (e.g., dystrophin deletion or duplication mutation found);
 - b. If genetic studies are negative (i.e., no mutation identified), positive muscle biopsy (e.g., absence of dystrophin protein);
2. Prescribed by or in consultation with a neurologist;
3. Failure of ≥ 6 month trial of prednisone as evidenced by pharmacy claims history within the last year, unless contraindicated or clinically significant adverse effects are experienced;
4. Member is ≥ 5 years of age;
5. Dose does not exceed 0.9 mg/kg/day.

Approval duration: 6 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. Duchenne Muscular Dystrophy (must meet all):

1. Currently receiving medication via Centene benefit, or member has previously met all initial approval criteria;
2. Documentation that member continues to benefit from corticosteroid therapy;
3. Dose does not exceed 0.9 mg/kg/day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background

Description/Mechanism of Action:

Deflazacort is a corticosteroid prodrug, whose active metabolite, 21-desDFZ, acts through the glucocorticoid receptor to exert anti-inflammatory and immunosuppressive effects. The precise mechanism by which deflazacort exerts its therapeutic effects in patients with DMD is unknown.

Formulations:

Tablets: 6 mg, 18 mg, 30 mg, and 36 mg

Oral suspension: 22.75 mg/mL

FDA Approved Indications:

Emflaza is a corticosteroid/oral tablet/oral suspension formulation indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older.

Appendices

Appendix A: Abbreviation Key

DMD: Duchenne muscular dystrophy

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	02/17	03/17

References

1. Emflaza Prescribing Information. Northbrook, IL: Marathon Pharmaceuticals, LLC; February 2017; Available at: <https://emflaza.com/>. Accessed February 21, 2017.
2. Gloss D, Moxley RT, Ashwal S, Oskoui M. Practice guideline update summary: Corticosteroid treatment of Duchenne muscular dystrophy: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016;86(5):465-472. doi:10.1212/WNL.0000000000002337.
3. Bushby K, Finkel R, Birnkrant DJ, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and pharmacological and psychosocial management. *Lancet Neurol*. 2010; 9(1): 77-93.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice;

peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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