

Clinical Policy: Deflazacort (Emflaza)

Reference Number: CP.PHAR.331

Effective Date: 04.01.17

Last Review Date: 02.21

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

Description

Deflazacort (Emflaza[™]) is a corticosteroid.

FDA Approved Indication(s)

Emflaza is indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 2 years of age and older.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval 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 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. Age \geq 2 years;
4. Failure of a \geq 6 month trial of prednisone, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 0.9 mg/kg per day.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Duchenne Muscular Dystrophy (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 0.9 mg/kg per day.

Approval duration:

Medicaid/HIM – 12 months

Commercial – Length of Benefit

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

DMD: Duchenne muscular dystrophy

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
prednisone*	0.75 mg/kg/day PO (preferred) <u>Alternative dosing regimens</u> <ul style="list-style-type: none"> • 0.3 mg/kg/day PO (<i>lesser efficacy and fewer adverse events</i>) • 10 mg/kg/weekend PO 	Varies based on weight

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): hypersensitivity to deflazacort or any of the inactive ingredients in Emflaza
- Boxed warning(s): none reported

Appendix D: General Information

- Examples of positive response to corticosteroid therapy (e.g., Emflaza, prednisone) include improvement in muscle strength tests (e.g., Medical Research Council [MRC] scale for muscle strength with 0 being no movement and 5 being normal strength), pulmonary function tests (e.g., forced vital capacity [FVC] and maximal expiratory pressure), walk tests (e.g., 6 minute walk test (6MWT) distance), and timed functional tests (e.g., standing from lying position; climbing 4 stairs; running/walking 30 feet; propelling a wheelchair 30 feet).
- In clinical trials, Emflaza has demonstrated similar efficacy to prednisone with regard to muscle strength, motor function, pulmonary function, and loss of ambulation. Emflaza may be associated with potentially less weight gain than prednisone; however, it may also be associated with more growth reduction and cataracts. In an evidence report published August 2019, the Institute for Clinical and Economic Review (ICER) concludes: "...we have moderate certainty that deflazacort has comparable or better net health benefits compared to prednisone."

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
DMD	0.9 mg/kg/dose PO QD	0.9 mg/kg/dose

VI. Product Availability

- Tablets: 6 mg, 18 mg, 30 mg, 36 mg
- Oral suspension: 22.75 mg/mL

VII. References

1. Emflaza Prescribing Information. South Plainfield, NJ: PTC Therapeutics, Inc.; June 2019; Available at: <https://www.emflaza.com>. Accessed October 9, 2020.
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. Reaffirmed on January 26, 2019.
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.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: <http://www.clinicalpharmacology-ip.com/>.
5. Birnkrant DJ, Bushby K, Bann CM, et al. Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management. *Lancet Neurol*. 2018; 17: 251-267.
6. Institute for Clinical and Economic Review. Deflazacort, eteplirsen, and golodirsen for Duchenne muscular dystrophy: Effectiveness and value. Published August 15, 2019. Available at: <https://icer-review.org/material/dmd-final-evidence-report>. Accessed October 9, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	02.17	03.17
1Q18 annual review: - Policies combined for Centene Medicaid and Commercial lines of business - No significant changes from previous corporate approved policy - Medicaid: Removed time period in which prednisone trial must have occurred. - References reviewed and updated.	11.13.17	02.18
1Q 2019 annual review: added HIM; no significant changes; references reviewed and updated.	10.25.18	02.19
RT4: no significant changes; updated age down to 2 years old per updated prescribing information.	06.18.19	
1Q 2020 annual review: no significant changes; references reviewed and updated.	10.08.19	02.20
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.09.20	02.21

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

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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.

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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.

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