Clinical Policy Title:	deflazacort
Policy Number:	RxA.364
Drug(s) Applied:	deflazacort
Original Policy Date:	03/06/2020
Last Review Date:	8/26/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

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 confirming dystrophin deletion or duplication mutation;
   b. Muscle biopsy confirming absence of dystrophin protein
2. Trial and failure of a ≥ 6-month trial of prednisone or prednisolone, unless contraindicated or clinically significant adverse effects are experienced.

Initial Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. Duchenne Muscular Dystrophy (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. 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. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4773944/. Accessed August 26th, 2024.
2. 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. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5869704/. Accessed August 26th, 2024.

Review/Revision History	Review/Revision Date	P&T Approval Date
Policy established.	01/2020	03/06/2020
Policy updated. 1. Formatting updated. 2. Continued therapy criteria updated.	07/01/2020	09/14/2020

3. References updated.		
Policy was reviewed: 1. Continued Therapy Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	05/29/2021	09/14/2021
Policy was reviewed: 1. References were reviewed and updated.	3/23/2022	07/18/2022
Policy was reviewed: 1. References were reviewed and updated.	04/18/2023	07/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Removed age and dosing. 2. Added prednisolone as another drug option. Updated continued therapy criteria.	04/1/2024	04/01/2024
Policy was reviewed. 1. Removed Emflaza from Drug(s) Applied. 2. Added generic to Drug(s) Applied for clarification. 3. Updated lookback period to 120 days for continued therapy approval.	8/26/2024	09/12/2024