Criteria Based Consultation Prescribing Program

CRITERIA FOR DRUG COVERAGE
deflazacort (EMFLAZA™)

**Initial approval criteria:** Non-formulary deflazacort (Emflaza™) will be covered for 12 months under the prescription drug benefit when the following criteria are met:

- Prescriber is a Neurologist experienced in the treatment of muscular dystrophy  
  -AND-
- Diagnosis of Duchenne Muscular Dystrophy (DMD) with confirmatory genetic testing  
  -AND-
- Patient is at least 5 years of age  
  -AND-
- Onset of muscle weakness before the age of 5  
  -AND-
- Patient has used prednisone for at least 12 months  
  -AND-
- Patient experienced clinically significant weight gain, defined as crossing at least two stanines on the weight growth chart, during the first two years of prednisone use  
  -AND-
- Patient has documented baseline hemoglobin A1c (a measure of average blood sugar levels), blood pressure, and body mass index (BMI)

**Continued use criteria:** Non-formulary deflazacort (Emflaza™) will continue to be covered for 12 months under the prescription drug benefit when the following criteria are met:

- Patient continues to be under the care of a Neurologist  
  -AND-
- Patient has hemoglobin A1c, blood pressure, and BMI monitored over the last 12 months  
  -AND-
- The patient is NOT experiencing persistent or worsening abnormal weight gain