Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	June 17, 2017 June 28, 2019, March 24, 2025

EMFLAZA® (deflazacort)

Clinical PA required (preferred): Emflaza®

Non-Preferred: Deflazacort

LENGTH OF AUTHORIZATION: Up to one year

REVIEW CRITERIA:

- Patient must be ≥ 2 years of age.
- Prescribed by or in consultation with a neurologist or a specialist in Duchenne Muscular Dystrophy (DMD) or neuromuscular disorders.
- Patient must have the diagnosis of DMD (supported with progress notes and confirmed genetic testing).
- Documentation of inadequate treatment response, contraindication or intolerance to a six month trial of oral prednisone (documentation required).

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/
- Available as 6mg, 18mg, 30mg, and 36mg Tablets and 22.75mg/ml Oral Suspension