GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
EMFLAZA PA SUMMARY

Preferred	Non-Preferred
Prednisone generic	Emflaza (deflazacort)

LENGTH OF AUTHORIZATION: Initial: 6 months, Reauthorization: 1 year

PA CRITERIA:

Emflaza

- Approvable for members with a diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing who have experienced an inadequate response after 3 months or allergy, contraindication or intolerable side effect with prednisone; AND
- Must be prescribed by or in consultation with a physician who specializes in Duchenne muscular dystrophy.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.