

Corticosteroids for Duchenne Muscular Dystrophy (Emflaza™, generics, Agamree®)

Policy # 00554

Original Effective Date: 04/19/2017

Current Effective Date: 03/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider deflazacort (Emflaza™, generics)[†] or vamorolone (Agamree®)[‡] for the treatment of Duchenne muscular dystrophy to be **eligible for coverage**.^{**}

Patient Selection Criteria

Coverage eligibility for deflazacort (Emflaza, generics) or vamorolone (Agamree) will be considered when the following criteria (A, B, C, **and** D) are met:

- A. Patient has a diagnosis of Duchenne muscular dystrophy; AND
- B. Patient is at least 2 years of age; AND
- C. Patient meets one of the following conditions (**I or II**):
 - I. Patient has tried generic prednisone or prednisolone for greater than or equal to 6 months AND according to the prescribing physician, the patient has had at least ONE of the following significant intolerable adverse effects (AEs) [a, b, c, **or** d]:
 - a) Cushingoid appearance; OR
 - b) Central (truncal) obesity; OR
 - c) Undesirable weight gain defined as a greater than or equal to 10% of body weight gain increase over a 6-month period; OR
 - d) Diabetes and/or hypertension that is difficult to manage according to the prescribing physician; OR
 - II. According to the prescribing physician, the patient has experienced a severe behavioral AE while on generic prednisone or prednisolone therapy that has or would require a prednisone or prednisolone dose reduction; AND

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met).*

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- D. If the request is for brand Emflaza, patient has tried and failed (e.g., intolerance or inadequate response) GENERIC deflazacort (e.g., deflazacort, Jaythari®, Kymbee™, Pyquvi™)‡ unless there is clinical evidence or patient history that suggests GENERIC deflazacort (e.g., deflazacort, Jaythari, Kymbee, Pyquvi) will be ineffective or cause an adverse reaction to the patient.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of deflazacort (Emflaza, Jaythari, generics) or vamorolone (Agamree) when the patient has NOT tried and failed generic prednisone or prednisolone OR does NOT have valid reasoning as to why generic prednisone has not/will not be sufficient to be **not medically necessary**.**

Based on review of available data, the Company considers the use of brand Emflaza when the patient has not tried and failed a generic deflazacort product (e.g., deflazacort, Jaythari, Kymbee, Pyquvi) to be **not medically necessary**.**

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of deflazacort (Emflaza, generics) or vamorolone (Agamree) when the patient selection criteria are not met (EXCEPT those denoted as **not medically necessary****) to be **investigational**.*

Background/Overview

Emflaza is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy in patients 2 years of age and older. The recommended dose of Emflaza is 0.9 mg/kg/day administered once daily by mouth. Emflaza is available in brand and generic 6 mg, 18 mg, 30 mg, and 36 mg tablets as well as a brand and generic oral suspension. Several FDA-approved generic equivalents of Emflaza are available. Certain products are marketed under proprietary names that may appear branded; however, these products are generics. Examples include Jaythari, Kymbee, and Pyquvi.

Agamree is another corticosteroid indicated for the treatment of Duchenne muscular dystrophy in patients 2 years of age and older. It is supplied as an oral suspension with a recommended dose of 6 mg/kg (up to a maximum of 300 mg) administered once daily.

Duchenne Muscular Dystrophy

Duchenne muscular dystrophy is a genetic condition and is the most common type of muscular dystrophy. DMD is caused by a lack of dystrophin, which is a protein that helps keep muscle cells intact. This disease most commonly affects boys, but in rare cases, it can affect girls. It is estimated

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that DMD occurs in 1 of every 3,600 male infants worldwide. Glucocorticoids are currently recommended in patients with DMD to slow the decline in muscle strength and function. Prior to the approval of Emflaza, there were no other corticosteroids approved by the FDA for the treatment of DMD. However, prednisone has been the mainstay of therapy for quite some time. In comparative trials, Emflaza and prednisone have shown similar efficacy. According to guidelines from the American Academy of Neurology, patients that experience Cushingoid appearance or obesity with prednisone may be switched to Emflaza. Currently, Emflaza seems to be a therapeutic alternative to prednisone. Guidelines have not yet been updated to include Agamree.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Emflaza is a corticosteroid indicated for the treatment of Duchenne muscular dystrophy in patients 2 years of age and older. It was approved in 2017.

Agamree was approved in 2023 for the treatment of Duchenne muscular dystrophy in patients 2 years of age and older.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Emflaza

The effectiveness of Emflaza for the treatment of DMD was established in a multicenter, randomized, double-blind, placebo-controlled, 52 week study conducted in the US and Canada. Patients were randomized to therapy with Emflaza (0.9 or 1.2 mg/kg/day), an active comparator (prednisone), or placebo. A comparison to placebo was made after 12 weeks of treatment. After 12 weeks, placebo patients were re-randomized to receive either Emflaza or the active comparator (prednisone). All patients continued treatment for an additional 40 weeks. Emflaza 0.9 mg/kg/day and prednisone showed a significant difference in muscle strength at week 12 relative to placebo. Improvement in motor function was also noted in both groups. From weeks 12 to 52, there was a significant improvement in average muscle strength score in the Emflaza 0.9 mg/kg/day group compared to the prednisone group. The prednisone group experienced central obesity and Cushingoid experience more often than the Emflaza group (25% vs. 43% for central obesity, 60% vs. 78% for Cushingoid appearance). Cataracts occurred in 4.4% of patients in the Emflaza group vs. 1.6% in the prednisone group.

An additional randomized, double-blind, placebo-controlled study evaluated Emflaza vs. placebo. The results of the analysis of the primary endpoint of average muscle strength scores in study 2 at 2 years were not statistically significant. The lack of statistical significance could possibly be due to

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only a limited number of patients remaining in the placebo arm (subjects were discontinued when they lost ambulation). Regardless, muscle strength scores at month 6 and 12, as well as the average time to loss of ambulation, numerically favored Emflaza in comparison with placebo.

Even though there was shown to be a statistical difference between Emflaza and prednisone, there was only a slight decrease in the MRC (medical research council) scale scores. The clinical meaningfulness of the difference is difficult to interpret as both treated groups had positive changes in MRC from baseline. The main difference in the therapies likely lies within the adverse reactions. As noted above, Emflaza currently stands as a therapeutic alternative to prednisone. This is supported in guidelines from the American Academy of Neurology; patients that experience Cushingoid appearance or obesity with prednisone may be switched to Emflaza.

Agamree

The effectiveness of Agamree for the treatment of DMD was evaluated in a multicenter, randomized, double-blind, parallel-group, placebo- and active-controlled, multinational 24-week study. The study randomized 121 male patients with DMD to one of the following treatment groups: Agamree 6 mg/kg/day (n = 30), Agamree 2 mg/kg/day (n = 30), prednisone 0.75 mg/kg/day (n = 31), or placebo (n = 30) for 24 weeks. After 24 weeks, patients on prednisone and placebo received either Agamree 6 mg/kg/day (n = 29) or Agamree 2 mg/kg/day (n = 29) for an additional 20 weeks. The study included patients 4 to < 7 years of age at time of enrollment in the study who were corticosteroid naïve and ambulatory, with a confirmed diagnosis of DMD.

The primary endpoint was the change from baseline to Week 24 in Time to Stand Test (TTSTAND) velocity for Agamree 6 mg/kg/day compared to placebo. TTSTAND velocity is a measure of muscle function that measures the time required for the patient to stand to an erect position from a supine position (floor). The key secondary endpoints consisted of change from baseline to Week 24 in TTSTAND velocity (Agamree 2 mg/kg/day vs placebo), 6 Minute Walk Test (6MWT) distance and Time to Run/Walk 10 meters (TTRW) velocity. The 6MWT measures the distance that a patient can walk on a flat, hard surface in a period of 6 minutes and TTRW measures the time that it takes a patient to run or walk 10 meters. The fixed sequential testing process was applied to the key secondary endpoints in the order listed above.

The primary endpoint and key secondary endpoints were met for the Agamree 6 mg/kg/day treatment group. Patients in the Agamree 6 mg/kg/day group had a mean change from baseline in TTSTAND velocity of 0.048 rises/sec compared to -0.012 rises/sec in the placebo group (p = 0.002).

References

1. Emflaza [package insert]. Marathon Pharmaceuticals, LLC. Northbrook, Illinois. Updated June 2019.
2. Emflaza Drug Evaluation. Express Scripts.
3. Gloss D, Moxley RT 3rd, 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.

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4. Agamree [package insert]. Catalyst Pharmaceuticals, Inc. Coral Gables, Florida. Updated January 2024.
5. Jaythari [package insert]. Zydus Pharmaceuticals, Inc. Pennington, NJ. Updated November 2025.
6. Kymbee [package insert]. Upsher-Smith Laboratories, LLC. Maple Grove, MN. Updated July 2025.
7. Pyquvi [package insert]. Aucta Pharmaceuticals, Inc. Piscataway, NJ. Updated July 2025.

Policy History

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04/06/2017	Medical Policy Committee review
04/19/2017	Medical Policy Implementation Committee approval. New policy.
04/05/2018	Medical Policy Committee review
04/18/2018	Medical Policy Implementation Committee approval. No change to coverage.
04/04/2019	Medical Policy Committee review
04/24/2019	Medical Policy Implementation Committee approval. No change to coverage.
09/05/2019	Medical Policy Committee review
09/11/2019	Medical Policy Implementation Committee approval. Updated age requirement to reflect FDA approval for ages 2 years and older.
09/03/2020	Medical Policy Committee review
09/09/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/02/2021	Medical Policy Committee review
09/08/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/01/2022	Medical Policy Committee review
09/14/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
09/07/2023	Medical Policy Committee review
09/13/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
04/04/2024	Medical Policy Committee review
04/10/2024	Medical Policy Implementation Committee approval. Changed title from “deflazacort (Emflaza)” to “Corticosteroids for Duchenne Muscular Dystrophy (Emflaza™, generics, Agamree®)”. Added Emflaza generics and new drug, Agamree, to policy with relevant background information. Updated criteria to allow trial of prednisolone as an alternative to prednisone.
06/05/2025	Medical Policy Committee review
06/11/2025	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

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02/05/2026 Medical Policy Committee review

02/11/2026 Medical Policy Implementation Committee approval. Added requirement for trial and failure of generic deflazacort products prior to brand Emflaza approval. Added clarification to background information regarding named generic products.

Next Scheduled Review Date: 02/2027

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.