[Date]

[Insurer Contact Name, Title]

[Name of Insurance Company]

[Insurance Company Address]

[City, State, ZIP Code]

RE: Appeal of DUVYZAT™ (givinostat) [Coverage, Prior Authorization] Decision

**Patient:** [Patient Name]

**Date of Birth:** [Date]

**Diagnosis:** [Diagnosis], [ICD-10-CM]

**Policy/Group Number:** [Numbers]

**Policyholder:** [Policyholder Name]

To whom it may concern:

My name is [Provider Name, Credentials], [Medical Specialty], [(National Provider Identifier Number)], and I am writing on behalf of my patient, [Patient Name], to request a review of a denied [claim, prior authorization] for DUVYZAT, indicated for the treatment of patients 6 years or older with Duchenne muscular dystrophy (DMD).1

[Insurance Company Name] has stated that it is denying [coverage, prior authorization] for DUVYZAT for the following reason(s):

* [List denial reasons]

**Rationale for Appealing Decision to Cover DUVYZAT Treatment**

[Depending on the reason for the denial, you may need to provide additional information and/or details regarding your rationale for prescribing DUVYZAT. Areas for further clarification may include but are not limited to the following:

* Patient’s age
* Patient’s clinical history and current clinical condition (consider including ambulatory status and any applicable functional test results)
* DMD diagnosis information (including genetic test results)
* Summary of patient’s past and current DMD medications with clinical response and duration of use
	+ Rationale for concurrent therapy if applicable (consider including mechanism of action and sequencing)
* Patient’s current weight and baseline platelet counts]

In summary, I am requesting an appeal of the denial of [coverage, prior authorization] for DUVYZAT for [Patient Name]. Based on the clinical information and treatment rationale above, I believe it is appropriate and medically necessary for [Patient Name] to receive immediate and adequate access to DUVYZAT. Please contact my office at [Telephone Number] if additional information is required. I look forward to your timely reconsideration and response.

Sincerely,

[Provider Name, Credentials, Medical Specialty, Provider Number]

[Provider Office Address]

Phone Number: [Provider Phone Number]

Fax Number: [Provider Fax Number]

**Enclosures** (suggested)**:**

* [Explanation of Benefits/Denial Letter]
* [DUVYZAT Prescribing Information]
* [Patient medical records and/or clinical notes]

**Reference:** 1.DUVYZAT. Prescribing information. ITF Therapeutics; 2024.

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