[Date]

[Insurer Contact Name, Title]

[Name of Insurance Company]

[Insurance Company Address]

[City, State, ZIP Code]

RE: Letter of Medical Necessity for DUVYZAT™ (givinostat)

**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 that [Insurance Company Name] approve coverage for DUVYZAT therapy, indicated for the treatment of patients 6 years or older with Duchenne muscular dystrophy (DMD).1

Based on my clinical judgment, I believe that DUVYZAT is medically necessary for [Patient Name] because [rationale for prescribing DUVYZAT].

[You may wish to include the following information:

* DMD diagnosis information (including genetic test results)
* Patient’s clinical history and current clinical condition (consider including ambulatory status and any applicable functional 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
* Other relevant information]

Based on the clinical data available to date, it is my medical opinion that initiating treatment with DUVYZAT is medically necessary for [Patient Name] and should be a covered and reimbursed service. Please contact my office at [Telephone Number] if additional information is required. I look forward to receiving your timely response and approval of this request.

Sincerely,

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

[Provider Office Address]

Phone Number: [Provider Phone Number]

Fax Number: [Provider Fax Number]

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

* [Patient medical records and/or clinical notes]
* [DUVYZAT Prescribing Information]
* [Peer-reviewed literature (if supporting rationale)]

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

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