Louisiana Medicaid
Givinostat (Duvyzat™)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for givinostat (Duvyzat™).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 6 years of age or older on the date of the request; **AND**
- The recipient has a documented diagnosis of Duchenne muscular dystrophy (DMD) confirmed by genetic testing; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a neurologist; **AND**
- The requested medication is prescribed concurrently with an oral corticosteroid, unless contraindicated or clinically significant adverse effects are experienced.

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is receiving clinical benefit from givinostat therapy, such as stabilization, maintenance, or improvement of muscle strength, or a slower disease progression relative to the projected natural course of DMD.

Duration of initial approval: 6 months
Duration of approval for continuation of therapy: 12 months

Reference

Duvyzat (givinostat) [package insert]. Concord, MA: ITF Therapeutics, LLC; March 2024. https://www.duvyzat.com/PI

Revision / Date	Implementation Date
Policy created / November 2024	March 2025