US Family Health Plan

Prior Authorization Request Form for

Givinostat (Duvyzat)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 6 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the requested medication prescribed by a neurologist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of Duchenne Muscular Dystrophy (DMD) that has been confirmed by genetic testing or muscle biopsy?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient ambulatory?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to, intolerability to, or has failed a trial of deflazacort (Emflaza)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the provider acknowledge the FDA safety alerts, warnings, precautions, drug interactions, and monitoring recommendations for the requested medication?	☐ Yes **Sign and date below**	☐ No **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[13 November 2024]