

givinostat (DuvyzatTM)

Policy # 00890

Original Effective Date: 10/14/2024

Current Effective Date: 10/01/2026

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 givinostat (DuvyzatTM)[†] for the treatment of Duchenne Muscular Dystrophy to be **eligible for coverage**.^{**}

Patient Selection Criteria

Coverage eligibility for givinostat (Duvyzat) will be considered when the following criteria are met:

- **Initial**
 - Patient has a diagnosis of Duchenne Muscular Dystrophy; AND
 - Diagnosis has been confirmed by genetic testing with a confirmed pathogenic variant in the dystrophin gene; AND
 - Patient is greater than or equal to 6 years of age; AND
 - Patient is ambulatory; 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.)*
 - Patient has been on a stable systemic corticosteroid therapy regimen for at least 6 months.
*(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.)*
- **Continuation**
 - Patient has received an initial authorization; AND
 - Patient continues to be ambulatory; 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.)*
 - According to the prescriber, the patient continues to benefit from therapy as demonstrated by a stabilization or slowed decline on timed function tests (e.g., 4-stair climb, 6-minute walk test, time-to-rise) or in the North Star Ambulatory Assessment (NSAA) score.
*(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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When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of givinostat (Duvyzat) when the patient is not ambulatory or has not been on a stable systemic corticosteroid regimen for at least 6 months to be **not medically necessary**.**

Based on review of available data, the Company considers the use of givinostat (Duvyzat) when the patient is not ambulatory or has not demonstrated a continued benefit from therapy 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 givinostat (Duvyzat) when patient selection criteria are not met (except those noted above as **not medically necessary****) to be **investigational**.*

Background/Overview

Duvyzat is a novel histone deacetylase (HDAC) inhibitor approved for the treatment of patients 6 years of age and older with Duchenne muscular dystrophy. It is thought to reduce the rate of decline in these patients by activating repair mechanisms that can prevent muscle degeneration and reduce inflammation. Duvyzat is dosed based on the patient's body weight and should be administered orally, twice daily, with food. The most common adverse reactions (seen in at least 10% of Duvyzat-treated patients) were diarrhea, abdominal pain, thrombocytopenia, nausea/vomiting, hypertriglyceridemia, and pyrexia.

DMD is a progressive, X-linked, degenerative neuromuscular disease that results in disabling muscle weakness and eventually leads to early death. It is caused by mutations in the *DMD* gene resulting in reduced or near absence of dystrophin, a protein that helps keep muscle cells intact. Boys with DMD are typically diagnosed at 3-5 years of age, and the estimated U.S. prevalence of DMD ranges from 10,000 to 15,000 males. There is no curative treatment for DMD. Current pharmacological approaches include corticosteroids and exon-skipping therapies. Corticosteroids such as prednisone, deflazacort (Emflaza[®], generics)[‡], and vamorolone (Agamree[™])[‡] are the standard of care for treatment of DMD due to their beneficial effects for improving motor function and pulmonary function, reducing the risk of scoliosis, delaying the loss of ambulation, and possibly delaying progression of cardiomyopathy and improving survival. Exon-skipping therapies work to increase dystrophin protein expression in patients that have skippable deletions in exons 51, 53, or 45, representing about 30% of the DMD population. Exon-skipping therapies increase dystrophin protein expression and may at best slow disease progression, but have not been proven to improve survival or functional outcomes.

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FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Duvyzat was approved in March 2024 for the treatment of Duchenne Muscular Dystrophy (DMD) in patients 6 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.

The effectiveness of Duvyzat for the treatment of Duchenne Muscular Dystrophy (DMD) was evaluated in a randomized, double-blind, placebo-controlled 18-month study. A total of 179 patients were randomized 2:1 to receive either Duvyzat (n = 118) or placebo (n = 61). A weight-based dose regimen was applied. The study included male patients 6 years of age and older with a confirmed diagnosis of DMD who were ambulatory and on a stable dosage of corticosteroids.

The primary endpoint was the change from baseline to Month 18 in 4-stair climb (4SC) time for Duvyzat compared to placebo. The 4SC is a measure of muscle function that tests the time it takes to climb 4 stairs. Patients treated with Duvyzat showed statistically significantly less decline in the 4SC than placebo with a mean change from baseline of 1.25 second vs 3.03 second for the placebo group. This corresponded to a treatment difference of -1.78 (95% CI: -3.46, -0.11).

References

1. Duvyzat [package insert]. Italfarmaco SPA. Madrid, Spain. Updated March 2024.
2. Duvyzat New Drug Review. IPD Analytics. Updated May 2024.

Policy History

Original Effective Date: 10/14/2024

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09/05/2024 Medical Policy Committee review

09/11/2024 Medical Policy Implementation Committee approval. New policy.

09/04/2025 Medical Policy Committee review

09/10/2025 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

09/09/2026 Pre Pharmacy & Therapeutics Committee review.

09/16/2026 Pharmacy & Therapeutics Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 09/2027

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*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.

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.

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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.