SAMPLE LETTER OF MEDICAL NECESSITY

Name
Insurance Company/Payer Name
Address
City, State, Zip

01-Jan-2025

RE: Member Name: Member Name
Member Number: Member Number
Group Number: Group Number

EXPEDITED REQUEST: Authorization for treatment with Ensacove™ (ensartinib)

This sample letter is for informational purposes only. Use of this information does not constitute medical or legal advice and does not guarantee coverage. It is not intended to be a substitute for, or an influence on, the independent clinical decision of the prescriber. Health plan requirements may vary. Please confirm the specific information required by your patient's health plan to ensure you are providing accurate and complete information. Note: When preparing the actual letter, use your professional/physician letterhead.

Dear Medical or Pharmacy Director:

I am writing to make an expedited authorization request for my patient to receive treatment with Ensacove™.

My request is supported by the following:

Summary of Patient History

[You may consider including (NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.)
• Patient's diagnosis, date of diagnosis, and history
• Previous therapies and procedures the patient has undergone for management of patient's condition
• Patient's response to these therapies
• Summary of your professional opinion of the patient's likely prognosis without treatment]

Rationale for Treatment

Considering the patient's history, condition, and the full Prescribing Information supporting use of Ensacove™. I believe treatment at this time is Provide Clinical Justification for Treatment
Provide Clinical Justification for Treatment - Continued

Given the urgent nature of this request, please provide an expedited authorization. Contact my office at Phone Number if I can provide you with any additional information to ensure prompt approval of this course of treatment.

Sincerely,

Doctor Name
Participating Provider Number

Enclosures

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