TEMPLATE LETTER OF MEDICAL NECESSITY

This example letter is provided for guidance and reference only.

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]

Patient Name: [Patient Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number]
Case ID Number: [Case ID Number (if available)]

To Whom It May Concern:

I am writing on behalf of my patient, [patient name], to provide information supporting medical necessity for ZYNYZ™ (retifanlimab-dlwr) treatment. In this letter, I am providing my patient's medical history, diagnosis, and a summary of their treatment plan. I have also provided a brief description of [patient name]'s previous treatments and a clinically based treatment rationale supporting the medical necessity for ZYNYZ.

Patient's Clinical / Medical History

- [Patient's ICD-10-CM diagnosis code and date of diagnosis]
- [Patient's first visit date and date of referral]
- [Patient's performance status]
- [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- [Patient's disease progression]
- [Any additional factors impacting ZYNYZ treatment selection]

Treatment Plan

- [Include plan of treatment: dosage, frequency, and length of treatment]
- [State the clinical rationale for treatment with ZYNYZ]

Summary

Based on the provided information, I believe ZYNYZ is medically necessary for [patient name]. Please find the enclosed additional documents [list any attachments] that support my clinical decision. If you need additional information for a timely approval, please contact my office at [office phone number].

Sincerely,

[Physician Name]
[Physician Address]
[Physician Phone]

Enclosures: [List any applicable enclosures such as prescribing information, patient medical history, relevant peer-reviewed articles, FDA approval letter, etc.]