[Date]

[Payer Name]

[Payer Address]

ATTN: [Appeals Department]

RE: [Patient Name]

[Policy ID/Group Number]

**REQUEST:** Authorization for treatment with IMAAVY™ (nipocalimab-aahu)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ **URGENT**

To Whom It May Concern:

My name is [Name], and I am a [board-certified medical specialty] [NPI] writing on behalf of my patient, [Patient Name], to request coverage for IMAAVY™. [Patient Name] has been under my care for [X months] for the treatment of [disease or symptoms]. IMAAVY™ is an FDA-approved therapy for this diagnosis. [I believe it is medically necessary for (Patient Name) to receive treatment with IMAAVY™, and it’s important that a formulary exception be made.]

[Plan name]has denied coverage of IMAAVY™ for [Patient Name]because [insert reason for denial as indicated on the explanation of benefits].In my judgment, [Product X]is not a medically appropriate treatment for [Patient Name],because he/she has [insert rationale, eg, personal medical history/family history, contraindication, comorbid condition, prior inadequate response, or adverse reaction to Product X].

* [Provide a brief medical history, including diagnosis, date of diagnosis; objective data confirming diagnosis such as procedures, imaging and/or lab results; current condition/symptoms; and previous therapy including dose, duration and response]
* [Discuss rationale for using IMAAVY™ versus other therapies on formulary. Insert your recommendation summary here, including your professional opinion of the patient’s likely prognosis or risk for disease progression without treatment with IMAAVY™]
* [List of pertinent medical records and, additionally, consider documents that provide further clinical information to support the recommendation, such as full Prescribing Information, peer-reviewed journal articles, or clinical guidelines] are enclosed, which offer additional support for the formulary exception request for IMAAVY™. Please consider coverage of IMAAVY™ for my patient

The attached copies of [clinical peer-reviewed literature, clinical guidelines, full Prescribing Information, imaging and/or
lab results if applicable]document that IMAAVY™ is an appropriate treatment option for this patient. If you disagree
with coverage and uphold this denial, I am requesting that a [dermatologist/rheumatologist/gastroenterologist] review
this documentation.

Given the urgent nature of this request, please provide a timely authorization. Please contact my office at [telephone number] if I can provide you with any additional information.

Sincerely,

[Physician Name]

[Physician’s medical specialty]

[Physician’s NPI]

[Physician’s practice name]

[Phone #]

[Fax #]

Enclosures [Include full Prescribing Information and the additional support noted above]