[Insert Physician Letterhead]

[Date]
To whom it may concern,

Member name	[Patient name]
Date of birth	[Patient date of birth]
Member ID number	[Member ID number]
Member group/policy number	[Member group/policy number]
Appeal case ID number	[Case ID number]
Denial date	[Date of appeal denial]

I am writing on behalf of my patient, [patient name], to appeal a denial of coverage and to request review by an oncology medical advisor to reconsider coverage for treatment of [relapsed or refractory multiple myeloma] with CARVYKTI® (ciltacabtagene autoleucel). According to your letter, coverage was denied due to [reason as stated in the denial letter].

My clinical assessment indicates that treatment with CARVYKTI® is medically necessary for [patient name]. The following is a brief description of the patient's medical history:
[Please use the below table to clearly outline relevant details that document medical necessity. Note: Exercise medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

Primary diagnosis	[Relapsed or refractory multiple myeloma]
ICD-10-CM code	[C90.00 or C90.02]
No. of prior therapies	[No. of prior therapies]
Description of prior therapies and treatment response	[Description of prior therapy 1 and patient's treatment response] [Description of prior therapy 2 and patient's treatment response] [Description of prior therapy 3 and patient's treatment response] [Description of prior therapy 4 and patient's treatment response]
Relevant disease-related characteristics	[Insert relevant disease-related characteristics including, but not limited to, histology and prognostic factors]
Clinical fitness	[Insert relevant details on the patient's clinical fitness including, but not limited to, ECOG performance status and/or organ function indicators]
Your professional opinion of the patient's likely prognosis or disease progression if they are not treated with CARVYKTI®	[Insert your professional opinion of the patient's likely prognosis or disease progression if they are not treated with CARVYKTI®]

ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification.

Rationale for treatment:
[Summarize clinical rationale for treatment, including supporting evidence from:

- Prescribing Information
- Treatment guidelines and/or recognized drug compendia
- Peer-reviewed literature]

In view of the above information and the enclosed documentation, I believe CARVYKTI® is medically necessary and appropriate and should be authorized for my patient.

Please note that our treatment center, [treatment center], is certified to administer CARVYKTI®, which is available through a restricted Risk Evaluation and Mitigation Strategy (REMS) program.

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

Sincerely,
[Provider Name and Signature]
[Provider Identification Number]
[Treatment Center Name and Address]

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