

[Insert Physician Letterhead]

[Date]

To whom it may concern,

<b>Member name</b>	[Patient name]
<b>Date of birth</b>	[Patient date of birth]
<b>Member ID number</b>	[Member ID number]
<b>Member group/policy number</b>	[Member group/policy number]
<b>Appeal case ID number</b>	[Case ID number]
<b>Denial date</b>	[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 autoleucl). 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.]

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