[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]

I am writing on behalf of my patient, [patient name], to document the medical necessity for treatment with CARVYKTI® (ciltacabtagene autoleucel) for [relapsed or refractory multiple myeloma].

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

Primary diagnosis	[Relapsed/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]
Site of medical service	[Include site type (eg, inpatient, hospital outpatient, outpatient clinic, or other) and rationale (eg, compliance or closely monitoring patients)]
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 drug compendia
- Peer-reviewed literature]

I believe CARVYKTI® is medically necessary for [patient name]'s medical condition based on the evidence summarized above. If you have further questions regarding this patient's current medical status, please do not hesitate to contact my office at [phone number].

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.

Sincerely,

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

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