[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]