SAMPLE LETTER TEMPLATE OF MEDICAL NECESSITY
FOR ASTELLAS PRODUCTS

To Prescriber: Please refer to the important safety information in the full Prescribing Information, including any Boxed Warning, when determining whether therapy is medically appropriate for the individual patient.

[Date]

[Contact Name]
[Insurance Company]
[Insurance Company Address]
[City, State ZIP Code]
[Fax Number]

ATTN: Prior Authorizations / Appeals

Re: Coverage of [Astellas Product Name / generic name /dosage form]
[Patient First Name] [Patient Last Name]
[Policy Number]
[Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis]

To whom it may concern:

I am submitting this letter to document the medical necessity of [Astellas Product Name] for [Patient Name]. [Astellas Product Name] is indicated for the treatment of [insert FDA approved indication]. [Patient Name] has been diagnosed with [Diagnosis] [insert any additional criteria necessary for on-label treatment] and has been receiving treatment for this diagnosis.

[Describe the patient's history, including diagnostic test results, previous and current treatment regimens and their outcomes]

Based on the information provided above, I have determined that treatment with [Astellas Product Name] is medically necessary and reasonable for [Patient Name]. Enclosed are copies of [Patient Name]'s medical records documenting related symptoms and medical necessity, as well as the Full Prescribing Information for [Astellas Product Name]. Please approve coverage for [Astellas Product Name] for [Patient Name] as recommended. Thank you for your prompt attention to this matter. If I can provide any additional information, please contact me.

Regards,

[Physician Name]
[NPI Number]
[Phone Number]
[Fax Number]