Sample Letter of Medical Necessity

This sample letter is for instructional purposes only, and this template letter is not meant to substitute for a physician's clinical decision-making. There is no requirement that any patient or eye care professional use any Astellas product in exchange for this information. This template provides information that may be required when sending a letter of medical necessity to a patient's health plan. A letter of medical necessity may be required to obtain a prior authorization decision and/or if there is a denial of coverage for IZERVAY™ (avacincaptad pegol intravitreal solution). Submitting a letter of medical necessity does not guarantee coverage. It is important to review the specific health plan requirements and each plan's submission process before you use this template. Please refer to the Important Safety Information in the full Prescribing Information when determining whether therapy is medically appropriate for your patient.

Please replace the pink, bracketed content with appropriate details and place the template in your standard practice letterhead.

[Date]

[Health plan name] [Patient's name]

ATTN: [Department] [Patient's plan-specific member ID]

[Medical/Pharmacy director name (if available)] [Date of birth]

[Health plan address] [Case number]

[City, State, ZIP code] [Dates of service]

Re: Letter of Medical Necessity for IZERVAY™ (avacincaptad pegol intravitreal solution)

Dear [Medical/Pharmacy director name],

I am [Eye care professional, credentials, specialty], writing on behalf of my patient, [Patient's first and last name], who I have been treating since [Date]. I am requesting coverage for IZERVAY, a complement inhibitor indicated for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) [ICD-10 codes], for [Patient name]. I believe [Patient name] is an appropriate candidate for treatment with IZERVAY based on the clinical rationale and relevant information provided.

In my medical opinion, initiating treatment with IZERVAY is medically necessary for [Patient's first name] given the medical history provided below:

- [Include information requested by payer]

If you have any further questions about this matter, please feel free to contact me at [Eye care professional phone number] or via email at [Eye care professional email]. Thank you for your time and consideration.

Sincerely,

[Eye care professional's signature] [Eye care professional name] [Eye care professional NPI] [Name of practice] [Phone number]

Enclosures: [List and attach additional documents, which may include Prescribing Information, clinical notes/medical records]