<Date>

<Payer Name>

<Payer Address>

**Re: CAR T Medical Necessity Documentation**

|  |  |
| --- | --- |
| **Patient Information**  | **CAR T Cell Therapy**  |
| Patient: <Patient Name>Group/Policy Number: <Group/Policy Number>Date of Birth: <Date of Birth> | <CAR T Product Name> |

To Whom It May Concern:

I am writing on behalf of my patient, <Patient Name>, to document medical necessity for the treatment with <CAR T Product Name> for <patient’s diagnosis>.

The following is a brief description of the patient’s medical history:

<Outline relevant details to document medical necessity, including:

* Primary diagnosis and ICD-10-CM code
* Relevant disease-related characteristics (eg, histology, prognostic factors)
* Prior regimens/lines of therapy and treatment response
* Clinical fitness (eg, ECOG performance status, organ function indicators)>

My clinical assessment indicates that <CAR T Product Name> is medically necessary for <Patient Name>. In addition, the following evidence supports my rationale for treatment:

<Refer to pertinent references and highlight supporting evidence, including:

* Prescribing Information
* Treatment guidelines and/or recognized drug compendia
* Peer-reviewed literature>

In view of the above information and the enclosed documentation, I believe <CAR T Product Name> is medically necessary and reasonable for this patient’s medical condition. Please note that our treatment center <CAR T Treatment Center Name> is certified to administer <CAR T Product Name>, which is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS).

Sincerely,

<Provider Name and Signature>

<Provider Identification Number and Contact Information>

<Treatment Center Name and Address>

Enclosed Documentation:

<Attach and list pertinent documentation, as appropriate>

 HE-US-2100722 10/21