The information contained in this template letter is provided by Astellas for informational purposes for patients who have been prescribed an Astellas medication. There is no requirement that any patient or healthcare provider use any Astellas product in exchange for this information, and this template letter is not meant to substitute for a prescriber's independent medical decision-making.

SAMPLE LETTER TEMPLATE OF FORMULARY EXCEPTION

To Prescriber: Please refer to the full Prescribing Information 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: [ICD-10-CM Code] [Diagnosis]

To Whom It May Concern:

I am writing to request a formulary exception to be granted for [Patient Name] for treatment with [Astellas Product Name]. [Payer Name] does not include [Astellas Product Name] on the approved formulary list.

[Patient Name] is diagnosed with [patient diagnosis]. I am a [board-certified] [physician type], and in my clinical judgment I believe that [Astellas Product Name] is the appropriate treatment. I am requesting that the plan remove any relevant NDC blocks so that [Astellas Product Name] can be made available to my patient as a preferred medication.

[Provide rationale for treatment]

I have enclosed additional documentation that supports the need for treatment with [Astellas Product Name]. In the best interest of my patient, I appreciate your immediate review and ask that a formulary exception be granted. If you have further questions, please feel free to call me at [telephone number] to discuss.

Regards,

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

[Enclosures: Full Prescribing Information, (suggested) Formulary Exception form if required (payer website), original Prior Authorization form, Denial Letter/Explanation of Benefits, patient medical history, additional supporting documentation]