[TEMPLATE]

Letter of Medical Necessity:

Use of Gamifant® (emapalumab-lzsg)

Date:

[Name of Medical Director] RE: Patient Name [_____]

[Health Plan] Policy Number [_____]

[Address] Claim Number [_____]

[City, State, Zip]

Dear **[Health Plan]**:

I am writing this letter of medical necessity in support of my request to treat **[patient name]** with Gamifant (emapalumab-lzsg).

[*Note: Include information about your credentials, specialty, and practice.*]

1. Patient-Specific Rationale for Treatment

In brief, based on the clinical data available to date, it is my medical opinion that initiating treatment with Gamifant for **[patient name]** is medically appropriate and necessary, and the procedures required for its administration should be a covered and reimbursed service. Below, this letter outlines **[patient name]**'s medical history and prognosis, and the rationale for treatment with Gamifant.

[*The following section is to be completed by the physician based on the patient's medical history and prognosis.*]

2. Summary of Patient's Medical History *[You may want to include]*:

- Patient's diagnosis and current condition
- Relevant medical history
- Previous therapies the patient has taken for the symptoms associated with his or her condition
- Patient's response to these therapies

3. Patient's Prognosis

[*Summary of the patient's likely prognosis without Gamifant treatment vs the patient's prognosis with Gamifant treatment.*]

Please call my office at **[telephone number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Doctor name and participating provider number]