

SAMPLE LETTER OF MEDICAL NECESSITY

This sample letter is intended to provide a general outline of what information should be submitted to payers to support and demonstrate medical necessity for FOLOTYN® (pralatrexate injection). For additional medical necessity documentation, please contact the Allos Support for Assisting Patients (ASAP) at 1-877-ASAP102 (272-7102). Additionally, the full prescribing information for FOLOTYN is provided, starting on page 2 of this document.

DATE

NAME (e.g., Medical Director or Manager of Medical Review)

PAYER

PO Box or STREET ADDRESS

CITY, STATE, ZIP CODE

Dear **CONTACT NAME**,

I am writing on behalf of my patient **INSERT PATIENT NAME**, to document the medical necessity for FOLOTYN® (pralatrexate injection) treatment.

FOLOTYN is indicated for the treatment of patients with relapsed or refractory peripheral T-cell lymphoma. Below, I provide information for my patient, including medical history, diagnosis and treatment rationale. Additionally, the FDA approved prescribing information for FOLOTYN is included for reference.

PATIENT INFORMATION SHOULD BE INSERTED TO INCLUDE:

- **AGE AND GENDER**
- **INITIAL DIAGNOSIS AND DIAGNOSIS DATE**
- **PATIENT HISTORY, LABORATORY RESULTS, AND ANY PREVIOUS TREATMENTS**
- **OUTLINE YOUR TREATMENT RATIONALE FOR FOLOTYN (NOTE THAT, IF THE TREATMENT IS NOT WITHIN THE FDA-APPROVED INDICATION, PROVIDE COPIES OF ANY SUPPORTIVE PUBLISHED CLINICAL LITERATURE AND/OR CLINICAL COMPENDIA REFERENCES**

Based on the supporting documentation and treatment rationale, I am confident you will agree that FOLOTYN is medically necessary for this patient. Please contact me if you require any additional information about this patient's case. Thank you in advance for your immediate attention to this very important patient request.

Sincerely,

PHYSICIAN NAME

Enclosures: **MAY INCLUDE COPIES OF PATIENT MEDICAL RECORD, FOLOTYN FULL PRESCRIBING INFORMATION, AND/OR OTHER SUPPORTING LITERATURE OR REPORTS**