A patient's health insurance plan/payer may require prior authorization or supporting documentation to process and cover a claim for treatment with EXDENSUR (depemokimab-ulaa). A prior authorization allows the health plan to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Letter of Medical Necessity will help explain the physician's rationale and clinical decision-making in choosing EXDENSUR. Please note that some health plans have specific forms that must be completed in order to request prior authorization or to document medical necessity.

The following Letter of Medical Necessity template for EXDENSUR can be customized based on your patient's medical history and demographic information.

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]
[Plan/Payer Name]
[Payer street address]
[Payer city, state, ZIP code]
Re: Letter of Medical Necessity [HCPCS Code] [Drug Name, Billing Unit]
Patient: [Patient Full Name]
Group/Policy Number: [Patient group & policy number]
Date(s) of Service: [Date(s)]
Diagnosis: [Code & Description]

Dear [Insert payer contact name and/or department]:

I am writing on behalf of my patient, [patient name/policy number], to document medical necessity for treatment with EXDENSUR (depemokimab-ulaa). The patient will be treated with EXDENSUR for [diagnosis].

This letter serves to document that [patient name] needs EXDENSUR, and that EXDENSUR is medically necessary for [him/her] as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatments.

EXDENSUR is indicated for the add-on maintenance treatment of severe asthma characterized by an eosinophilic phenotype in adult and pediatric patients aged 12 years and older.

[Patient name] is a/an [age]-year-old [male/female] diagnosed with [diagnosis]. [Patient name] has been in my care since [date]. As a result of [diagnosis], my patient [enter a brief description of patient history]. Additionally, [patient name] has tried [previous therapies] and [outcomes]. The patient is currently on [current therapy] for the treatment of [severe asthma / CRSwNP]. The attached medical records document [patient name]'s clinical condition and medical necessity for treatments with EXDENSUR.

Based on the above facts, I am confident that you will agree that EXDENSUR is indicated and medically necessary for this patient. The plan of treatment is to start the patient on EXDENSUR [dose]. Administration of EXDENSUR is planned for [date] and will be continued approximately once every [# of week/s]. Please consider coverage of EXDENSUR on [patient name]'s behalf and approve use and subsequent payment for EXDENSUR as planned.

Please refer to the enclosed Prescribing Information for EXDENSUR. If you have any further questions regarding this matter, please do not hesitate to call me at [physician telephone number].

Thank you for your prompt attention to this matter.

Sincerely,
[Physician's name], [degree initials], [physician's practice name]

Suggested Enclosures:

- Medical records and clinical notes and labs
- FDA approval letter available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm?event=browseByLetter.page&productLetter=E
- Prescribing Information (PI) - please also visit: https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Exdensur/pdf/EXDENSUR-PI-PIL.PDF
- Important Safety Information