Instructions:

This template is offered as a resource a healthcare provider could use when responding to a request from a patient's health insurance company to provide a letter of medical necessity for CALQUENCE® (acalabrutinib). Some or all of the following attachments may be helpful to include with the letter of medical necessity: required insurer forms, Prescribing Information, and any other additional supporting documents. If you need additional references, please contact AstraZeneca Access 360™ at 1-844-ASK-A360 (1-844-275-2360).

When determining if treatment with CALQUENCE is medically appropriate for a patient, please refer to the full Prescribing Information, including Patient Information.

Use of the letter does not guarantee that the insurance company will provide reimbursement for the medicine requested, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Medical Necessity
(Healthcare Provider Letterhead)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of CALQUENCE® (acalabrutinib)
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of CALQUENCE® (acalabrutinib) for the treatment of [Diagnosis].

Patient History and Diagnosis

[Provide a Brief Description of the Patient's Medical Condition Here.]
[Describe why other treatment options are not appropriate for the patient.]
[Include a Short Summary of the Patient's Medical History, including documentation of condition being treated and any previous therapies, including duration of use and reason for discontinuation.]
[Explain why you believe it is Medically Necessary for Patient to receive CALQUENCE.]
[Describe the Potential Consequences to the Patient if they do not receive CALQUENCE.]
[Obtain and Attach Supporting Letters from any other Specialist(s) that is currently providing or has previously provided Care to the Patient.]

To conclude, CALQUENCE is medically necessary for this patient's medical condition. Please contact me at [insert phone number] if any additional information is required to ensure the prompt approval of CALQUENCE.

Sincerely,
[Physician's Name]
[Physician's Practice Name]

If this request is denied, I am requesting an expedited Exception review by a "Like" specialist.

Enclosures
[Include Indication and Important Safety Information]
[Include full Prescribing Information, including Patient Information for CALQUENCE]

References

[Include CALQUENCE PI]

[Include other relevant references and publications regarding CALQUENCE]

AstraZeneca Access 360™ provides patients and their providers access and reimbursement support for CALQUENCE. Reimbursement is not guaranteed.