**Sample Letter of Medical Necessity**

**Template Instructions:**

This template is offered as a resource a healthcare provider may use when responding to the patient’s health benefits company request for a letter of medical necessity for SAPHNELO™ (anifrolumab-fnia). As you review the template below, please note that you will need to populate or provide the information in bracketed pink font ([xxx]).

**Documents typically included with the letter of medical necessity are a copy of the denial or explanation of benefits, any supporting documents, and Prescribing Information.** If you have questions, please contact our Information Center at 1-800-236-9933.

**Use of this Letter of Medical Necessity does not guarantee that the insurance company will approve your request for SAPHNELO and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.**

**IMPORTANT NOTE: This template is intended to be completed by the patient’s treating physician. Prior to submission, please delete these instructions and complete all sections below.**

***[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]

**Patient Name:** [Patient Name]

**Patient Date of Birth:** [Patient Date of Birth]

**Policy Number:** [Policy Number]

**Group Number:** [Group Number]

**RE: Letter of Medical Necessity for SAPHNELO™ (anifrolumab-fnia) injection, for intravenous
use 300 mg/2 mL**

Dear [Name of the Contact Person at the Payer],

I am writing on behalf of my patient, [Patient Name], to document medical necessity for

SAPHNELO™ (anifrolumab-fnia) injection, for intravenous use for the treatment of [Specific Diagnosis]. This letter provides information about the patient’s medical history and diagnosis and a statement summarizing my treatment rationale.

**Patient’s Medical History and Treatment plan**

[Patient Name] is a [age]-year-old [gender] who has been under treatment for [diagnosis][ICD-10-CM] since [date]. [Provide a Brief Description of the patient’s Medical History, lab results]. The treatment regimen has included [list past and/or existing treatment and patient’s response to treatment].

[Explain why you believe it is Medically Necessary for patient to receive SAPHNELO.] [Include treatment plan with SAPHNELO (dosage, frequency) and how you expect it will help the patient.]

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Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of SAPHNELO injection, for intravenous use. I continue to believe SAPHNELO is indicated and medically necessary for this patient. If you have further questions or you require additional information, please contact me at [Physician Phone Number].

Sincerely,

[Physician’s Name]

[Physician’s Practice Name]

References

[Include SAPHNELO PI]

[Include other relevant references and publications regarding SAPHNELO]

[Clinical notes & lab results]

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