

# SAMPLE LETTER OF MEDICAL EXCEPTION

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[Date]

[Payer Name]

[Payer Street Address]

[Payer City, State, and Zip Code]

Patient Name: [Patient Full Name]

Date of Birth: [Patient Birth Date]

Member ID: [Patient Member ID Number]

Policy or Group Number: [Patient Policy or Group Number]

Case ID Number: [Case ID Number (if available)]

To Whom It May Concern,

I understand that the [plan name] policy for [patient name] requires [restriction description] prior to approving MONJUVI® (tafasitamab-cxix) treatment. However, I believe that [patient name] requires MONJUVI without [restriction description] due to clinical and medical circumstances. Please see below for details about symptoms, previous treatments, medical history, and treatment rationale that supports the claim for medical exception for [patient name].

## Patient's Clinical / Medical History

- ▶ [Patient's ICD-10-CM diagnosis code and date of diagnosis]
- ▶ [Patient's first visit date and date of referral]
- ▶ [Patient's performance status]
- ▶ [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- ▶ [Patient's disease progression and scan history]
- ▶ [Any additional factors impacting MONJUVI treatment selection]

## Justification for Medical Exception

- ▶ [State the clinical rationale for treatment with MONJUVI]
- ▶ [Describe why the plan requirement is not appropriate for your patient]
- ▶ [List concerns that may include experience on similar therapies, drug side effects, and any other patient-specific considerations]

## Treatment Plan

- ▶ [Include plan of treatment: dosage, frequency, and length of treatment]
- ▶ [Clinical rationale for the use of MONJUVI]

## Summary

Based on the above, I am certain that you will agree MONJUVI is an appropriate treatment for [patient name]. A timely approval of MONJUVI by [plan name] without [restriction description] would be greatly appreciated by both myself and my patient. Please contact me at [phone number] if you need more information to approve a medical exception for [patient name].

[Physician Name]

[Physician Address]

[Physician Phone]

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**Enclosures:** [List any applicable enclosures such as prescribing information, patient medical history, relevant peer-reviewed articles, FDA approval letter, etc.]