Sample Format Letter of Medical Necessity

[Insert physician letterhead]

[Name] RE: Member Name _____

[Insurance Company/Payer Name] Member Number _____

[Address] Group Number _____

[City, State, ZIP]

EXPEDITED REQUEST: Authorization for treatment with SYLVANT® (siltuximab)

Dear:

I am writing to support my request for an expedited authorization for my patient, **[insert patient name]**, to receive intravenous treatment with SYLVANT® (siltuximab) for the treatment of Multicentric Castleman's Disease (MCD) in a patient who is human immunodeficiency virus (HIV-)-negative and human herpesvirus-8 (HHC-8) -negative. This request is consistent with the indication statement for SYLVANT®. My request is supported by the following:

Summary of Patient History [you may want to include]:

[Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

- **Patient's diagnosis, date of diagnosis, lab results and date, current condition, and history**
- **Previous therapies and procedures the patient has undergone for management of their condition**
- **Patient's response to these therapies**
- **Brief description of the patient's recent symptoms and conditions**

Rationale for Treatment

Considering the patient's history, condition, and the full Prescribing Information supporting uses of SYLVANT®, I believe treatment with SYLVANT® at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service.

The accompanying full Prescribing Information provides the approved clinical information for SYLVANT®.

Given the urgent nature of this request, please provide an expedited authorization. Contact my office at [insert telephone number] if I can provide you with any additional information.

Sincerely,

[Insert Doctor name and
participating provider number]

Enclosures