[Your name]

[Your address]

[Your city, state, ZIP]

[Your phone number]

[Tax ID#]

[Date]

[Name of Rx Plan]

[Address of Rx Plan]

Member ID:

Group or Medicare #:

Claim or Explanation of Benefit #:

 Re: Action Required: Request for Reconsideration for VEGZELMA® (bevacizumab-adcd) for [Patient Name]

To whom it may concern:

My name is [Physician Name]and I am a [board-certified medical specialty] [NPI]. I am writing this letter to provide additional information to support my request to treat [Patient Name], who has been diagnosed with [condition], [ICD code(s)], with VEGZELMA, a product indicated for the treatment of colorectal cancer in adult patients.

In brief, treating [Patient Name]with VEGZELMA is medically appropriate and necessary and should be a covered and reimbursed service. [Health Plan Name]determined VEGZELMA was not covered for [Patient Name]because [reason(s) for denial]. This letter provides my clinical rationale and relevant information about the patient's medical history and treatment.

**Patient’s Clinical History**

[Must include: Patient’s clinical / medical history, diagnosis, condition, and symptoms:] [Patient Name]is [a/an] [age]-year-old [male/female]patient who has been diagnosed with [condition][ICD-10-code(s)]as of [date of diagnosis]. [He/she] has been in my care since [date].

[Include any additional considerations here:]

My rationale for prescribing VEGZELMA is based on [include a brief disease course of patient, including history of disease, laboratory results, symptoms, and previous treatments (including names, dosages, frequency, and length). If the patient has discontinued treatment, please include information on the reasons for such discontinuation, such as inability to tolerate a previous treatment, lack of response and or side effects, e.g. You may also want to include medical reasoning for choosing to bypass any

alternative medications preferred by the health plan such as COVID-19 risk exposure due to multiple infusions, patient may not be able to comply with labeled multiple dosing requirements of preferred products over an extended period of time, and treatment guidelines such as NCCN, KDIGO, and NICE].

[Please exercise your medical judgment and discretion when providing diagnosis and characterization of the patient’s medical condition].

**Treatment Plan**

On [date], the FDA approved VEGZELMA for the treatment of [Indication]. [Include plan of treatment (dosage, length of treatment) and clinical practice guidelines that support the use of] VEGZELMA. [Consider mentioning experts in the field who also support the treatment].

**Summary**

Based on the patient’s condition and medical history, as well as my experience treating patients with colorectal cancer, I believe treatment with VEGZELMA is warranted, appropriate, and medically necessary in this case. The accompanying package insert provides the approved clinical information for VEGZELMA. I have attached relevant lab test analyses and medical records to support my decision.

I am requesting an immediate and expedited review of this appeal by a board certified and specialty matched physician who can render a decision based upon the standards of care outlined above. If you have any further questions about this matter, please contact me at [Physician Phone Number]or via e- mail at [Physician Email]. I look forward to receiving your timely response and approval of this claim.

If you do not feel that the information provided has established medical necessity, please provide me with your detailed rationale based upon the standards of care, the specialty of the physician who reviewed this case, and whether they are board certified in an applicable medical specialty.

Sincerely,

[Physician Name] [Physician Signature]

[Physician Address]

[Physician Phone Number]

**Enclosures**

[List enclosures, which may include medical records/clinical notes for VEGZELMA, VEGZELMA Prescribing Information, and other supporting documentation].

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