Payers may deny coverage of claims for treatment with JEMPERLI (dostarlimab-gxly). A patient-specific letter of appeal and supporting documentation will help to explain the physician's rationale and clinical decision-making in treating with JEMPERLI. The following is a sample letter of appeal for JEMPERLI that should be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to appeal a denied claim and to document medical necessity.*

SAMPLE LETTER OF APPEAL

[Date]

[Contact Name of medical director or other Payer representative] [Contact Title]

[Name of Health Insurance Company] [Street Address, City, State, Zip]

Re: Letter of Medical Necessity/Appeal Letter for [HCPCS Code] [Drug name, billing unit]

Patient: [Patient Name] Group/Policy Number: [Number]

Date(s) of Service: [Dates] Diagnosis: [Code & Description]

Dear [Insert contact name or department]:

I have recently received a [DENIAL FOR PAYMENT] for a claim for JEMPERLI (dostarlimab-gxly). You have indicated that JEMPERLI is not covered by [INSURANCE PLAN NAME] because [REASON FOR DENIAL]. This letter serves as a request for reconsideration of a claim for charges of JEMPERLI administered by intravenous infusion to [PATIENT NAME] on [DATE(S) OF SERVICE].

[PATIENT NAME] has been under my treatment for diagnosis of [DIAGNOSIS INFORMATION] since [DATE]. Due to the patient's clinical condition, the plan of treatment was to start the patient on JEMPERLI. JEMPERLI was initially administered on [DATE OF TREATMENT] and continued approximately every [FREQUENCY]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with JEMPERLI.

JEMPERLI is indicated for the treatment of adult patients with mismatch repair deficient (dMMR) recurrent or advanced:

- endometrial cancer, as determined by an FDA-approved test, that has progressed on or following prior treatment with a platinum-containing regimen in any setting an are not candidates for curative surgery or radiation, or
- solid tumors, as determined by an FDA-approved test, that have progressed on or following prior treatment and who have no satisfactory alternative treatment options. *

* These indications is approved under accelerated approval based on tumor response rate and durability of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Because of [INSERT RELEVANT PATIENT INFORMATION SUCH AS HISTORY, DIAGNOSIS], I have administered JEMPERLI as a medically necessary part of this patient's treatment, and we would appreciate your reconsideration of the [DATE(S) OF SERVICE] claim for [PATIENT NAME]. Please contact me at [PHYSICIAN PHONE NUMBER] if you require additional information or have any further questions.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician's Name], [Degree Initials] [Physician's practice name]

Enclosures:

[Original Claim Form]

[Denial/Explanation of Benefits]

[Additional Supporting Documents]