Instructions
This sample is offered as a resource for healthcare professionals to use when writing a letter of medical necessity to a patient's insurance company.

Along with the letter of medical necessity, remember to include important enclosures, including:

- The prescribing information for the prescribed medication
- Any other additional supporting documents

This sample letter is for informational purposes only. It provides an example of the type of information that may be required when responding to a request from a patient's insurance company related to coverage. Use of the sample letter provided below does not guarantee that the insurance company will provide reimbursement for TG Therapeutics' medicines, and is not intended to be a substitute for, or an influence on, the independent medical judgment of the healthcare provider. There is no requirement that any patient or healthcare provider use any TG Therapeutics product in exchange for this information.

Sample Letter of Medical Necessity
(Healthcare Provider Letterhead)

[Date]
[Payer Name]
[Payer Address]
[City, State, ZIP Code]
[Payer Phone and Fax Number]

Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Member Identification Number: [Member Identification Number]
Group Number: [Number]

REQUEST: Authorization for treatment with UKONIQ™ (umbralisib)
REQUEST TYPE: ☐ Standard ☐ Expedited

DIAGNOSIS: [Insert Diagnosis] [Insert ICD-10-CM]
DOSAGE: [Insert Dose & Frequency]

Dear **[Authorization Reviewer]**:

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of UKONIQ™ (umbralisib) 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 to support this request.

Patient History and Diagnosis
[Insert brief description of the patient's current medical condition]
[Insert short summary of the patient's medical history (eg, lab results, prior treatments), as applicable]

Rationale for Treatment
[Explain why UKONIQ is the most clinically appropriate option for this patient]
Considering the patient's history, condition, and the full Prescribing Information supporting uses of UKONIQ, I believe treatment with UKONIQ at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service.
[Describe the potential consequences to the patient if they do not receive this medicine]
[Obtain and attach supporting letters of medical necessity from any specialist who is or has provided care to the patient]
[Include medicine indication information]
[Include medicine administration information]

To conclude, UKONIQ is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of UKONIQ.

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

Sincerely,

[Physician's Name]
[Physician's Practice Name]
[Physician's Practice Name]
[Physician's Practice Address]
[City, State, ZIP Code]
[Physician Phone and Fax Number]

Enclosures
[Include prescribing information for the prescribed medication]
[Relevant clinical documentation, such as history and physical, progress notes, and treatment history]
[Applicable coverage policies]
[Include other relevant clinical documentation, such as history and physical, progress notes, treatment history, references and publications regarding medicine]

The enclosed information supports the claim that treatment with UKONIQ is medically necessary.