

[Physician letterhead]

[Date]

[Health plan name]

ATTN: [Contact title/medical director]

[Contact name (if available)]

[Health plan address]

[City, State ZIP]

Re: Letter of Medical Necessity for INFUGEM™ (gemcitabine in a 0.9% sodium chloride injection), 10 mg/mL

[Patient name]

[Date of birth]

[Insurance ID number]

[Insurance group number]

[Case ID number]

[Dates of service]

Dear [Contact name/medical director],

This letter is sent on behalf of [patient's name] to document that [he/she] has been diagnosed with [specify type and classification of cancer] and requires treatment with INFUGEM™. I am writing to document my patient's medical history and diagnosis and summarize my treatment rationale. Treatment with INFUGEM™ [dose, frequency] is medically appropriate and necessary for this patient.

[Patient's name] is a [age]-year-old [male/female] who was diagnosed with [specify type and classification of cancer] on [list date of diagnosis]. [Patient's name] has been in my care since [date] and has [specify type and classification of cancer], which has affected [specify the organs that have been affected by the cancer and the degree of metastasis] of [his/her] body. [List any sensitive body surface areas involved and symptoms.]

[Indicate here if the patient is immunocompromised, has renal or hepatic impairment, has recently received radiation therapy, is a male/female of reproductive potential, or is pregnant]. I am attesting that my patient [does/does not] have the conditions listed above.

[If the patient has any of the conditions mentioned above, please list them below.]

INFUGEM™ [was/will be] prescribed to [patient's name] for the treatment of [specify type and classification of cancer]. Enclosed you will find other relevant supporting documentation.

[Provide any other information that in your professional medical judgment is relevant, including but not limited to a brief summary of the patient's history and current condition (eg, any previous treatments, contraindications for other treatments, and what factors led you to recommend the use of INFUGEM™).]

Please contact my office by calling [physician's phone number] for any additional information you may require in support of this request. I look forward to your timely approval.

Sincerely,

[Physician's signature]

[Physician's name]

[List additional documents, which may include package insert for INFUGEM™, copy of patient's medical records, diagnostic forms and photos of affected areas, or other supporting documentation.]

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