

[Insert Physician Letterhead]

[Sample Letter of Exception]

This template is intended to be used as a resource. It does not guarantee coverage. Please use your discretion to modify any content in the template based on your medical judgement; you may also write your own. Remember to remove all instructions before saving the document.]

Attn: [Insert Name of Medical Director]
[Insert Payer Name]
[Insert Address]
[Insert City, State, ZIP]

RE: [Insert Patient Full Name]
[Insert Gender and Date of Birth]
[Insert Policy Number]
[Insert Group Number]

REQUEST: Authorization for treatment with TALZENNA® (talazoparib)
DIAGNOSIS: [Insert applicable diagnosis (e.g., mCRPC) and its ICD-10-CM code]
DOSAGE: [Insert dose, frequency, and days supplied]
REQUEST TYPE: Standard EXPEDITED

[Insert Date]

Dear [Insert name]:

I am writing on behalf of my patient, [insert patient name], who was diagnosed with [insert diagnosis (e.g., mCRPC) and ICD-10-CM code], to request a formulary exception for TALZENNA®, dosed concomitantly with enzalutamide. My request is supported by the following:

Summary of Patient's Diagnosis

[Insert patient's diagnosis, date of diagnosis, lab results and date, and current medical condition]

Summary of Treatment History

[Exercise medical judgement and discretion when inserting the following:

- Diagnosis (ICD-10-CM) and dates of initial diagnosis and recurrence
- Laboratory/imaging results and pathology reports showing disease progression and metastasis
- Prior treatments and procedures for the cancer (dosage, treatment duration, clinical response, and reasons for discontinuation)
- Current condition, comorbidities, and intolerance to other therapies
- Physician opinion of patient prognosis or disease progression]

Rationale for Treatment

Considering the patient's medical history, current medical condition, and the supporting prescribing information for TALZENNA® for [insert indication and ICD-10-CM code], I believe treatment with TALZENNA® at this time is warranted, appropriate, and medically necessary for this patient. For TALZENNA® clinical information, please see the accompanying full Prescribing Information [and additional supporting documentation].

Please contact me at [insert phone number or e-mail address] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Insert physician name and participating provider number]

Enclosure: TALZENNA® full Prescribing Information[, insert any additional supporting documentation: published articles and clinical guidelines from ASCO or NCCN, laboratory/imaging results and pathology reports, and medical records documenting treatment history]