**This letter is provided as an example for your background information and is not intended to be directive nor should it be construed as clinical or reimbursement advice. Physicians should exercise medical judgment and discretion to appropriately diagnose and characterize the individual patient's medical condition. In addition, healthcare providers are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.**

[Provider Letterhead]

[Date]
[Contact name – usually the health plan's medical or pharmacy director]
[Contact title]
[Name of insurance company]
[Address]
[City, State, Zip code]
Re: [Patient's full name]
[Policy number][Group number]
[Claim # or reference #]
[Date of birth]

Dear [insert contact name]: [if you do not have a contact name, delete Dear and use: To whom it may concern:]

I am writing to request an expedited appeal, reconsidering your denial of coverage for [Kite CAR T Product], suspension for intravenous infusion, which I prescribed for my patient, [insert patient's full name].

It is our understanding that [name of health plan] is denying coverage. Your reasons for denial are [insert the reasons included in the letter from the patient's health plan]. We believe that [Kite CAR T Product] is medically necessary to treat [patient name's] medical condition.

Listed below are the patient's diagnosis, medical history, and treatment plan, which confirm the medical necessity and appropriateness of treatment with [Kite CAR T Product].

**Patient's diagnosis, medical history, and treatment plan**

[Insert sufficient information regarding the patient's diagnosis, medical history, including previous lines of therapies and results, and treatment plan]

[Patient name] is [a/an] [age]-year-old patient with [diagnosis] as of [date]. [Patient name] has been in my care since [date], having been referred to me by [referring healthcare provider name], who has been [patient's name's] treating healthcare provider since [date]. [Underlined copy is optional, delete if there is no referring healthcare provider].

As a result of this diagnosis, [he/she] [describe resulting condition, including dates and results from any relevant patient assessments]. Additionally, [patient name] has previously tried and failed to achieve a durable response with the following treatments: [include all other drugs and therapies tried, including details of dates and any results, inadequate response, or adverse events].

[Provide a brief description of patient's symptoms and therapy to date.]

I hope you will agree [Kite CAR T Product] is appropriate and necessary for [insert patient's name] and will provide coverage for this treatment. Enclosed in support of this appeal are: [insert description of supporting documents].

[Examples of supporting documentation to include]

- Consensus statement or treatment guidelines (ie, NCCN)
- Diagnostic test results
- FDA approval letter
- Medical literature
- Patient chart notes and medical records
- Peer-reviewed journal articles
- Prescribing Information
- Treatment studies or clinical trials

Thank you in advance for your immediate attention to this request. This treatment is vital in order to improve and ultimately maintain [his/her] health and life. In the absence of this medically necessary treatment, the patient can succumb to this disease.

Please contact me at [insert office telephone number] or via e-mail at [insert healthcare provider's e-mail address] for any additional information you may require regarding this appeal.

Sincerely,
[Healthcare provider's name and signature]

Attachments: [List all attachments here. Enclose the denial letter and supporting documentation with this letter]

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