[Insert Physician Letterhead]

[**Sample Letter of Medical Necessity**
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 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], to document the medical necessity of TALZENNA® for [insert diagnosis and ICD-10-CM code], 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.

The following documentation is enclosed:
- TALZENNA® full Prescribing Information
- [Insert published articles and clinical guidelines (i.e., ASCO and NCCN)
- [Insert laboratory/imaging results and pathology reports]
- [Insert medical records documenting treatment history]

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]

If this request is denied, I am requesting an expedited Exception review by a professional in my specialty.

Enclosure: [Include full Prescribing Information and any additional supporting documentation]

