[Physician Practice Letterhead at the top of the letter]

[Date]

[Name of Medical/Formulary Director]

[Name of Insurance Company]

[Address]

[City, State Zip Code]

**Re: [Patient Name, Group Policy Number, Date of Birth, Case Identification]—Formulary Exception Request for BESREMi**® **(ropeginterferon alfa-2b-njft) injection, for subcutaneous use**

Dear [Medical/Formulary Director Name],

My name is [HCP name], and I am a [board-certified medical specialty] [NPI]. I am writing to request a formulary exception for BESREMi for my patient, [Patient Name], who is currently a member of [name of health plan].

I have included additional information to support my decision to treat my patient with BESREMi. As you will note from the information below and attached, BESREMi is medically necessary and appropriate for [Patient Name]. This letter includes information about [Patient Name’s] medical history, [Patient Name’s] prognoses, and my medical rationale for selecting BESREMi. Therefore, I am requesting the plan remove any relevant NDC blocks so BESREMi can be made available to my patient as an approved medication.

**Summary of Medical History**

[Patient Name] is a/an [Age]-year-old [Sex]. [He/She] was diagnosed with polycythemia vera (PV), a myeloproliferative neoplasm, on [Date].

[Include a brief description of patient’s medical history and attach patient’s chart notes].

[Include BESREMi Package Insert and note that use is within labeled indication].

**Treatment Rationale**

Given my patient’s medical history, [his/her lack of response to other medications,] [intolerance to other therapies,] and the patient’s current condition and prognosis, I strongly believe that the use of BESREMi is medically necessary and appropriate for [Patient Name], and coverage should be approved.

[Include any relevant clinical guidelines, such as NCCN guidelines]

**Please call me or my office staff at [Physician telephone number OR Practice telephone number] if I can provide you with any additional information. I look forward to receiving your timely response and approval of BESREMi for [Patient Name].**

Sincerely,

[Prescriber Signature]

[Prescriber Name]

[Attachments: Enclose supporting documentation]

US-BSRM-2100057 11/2021