Sample Letter of Medical Necessity—Doptelet® (avatrombopag) and Doptelet® Sprinkle (avatrombopag)

[The following is a sample Letter of Medical Necessity. The text within pink brackets is templated and should be replaced with pertinent information for the individual patient on whose behalf you are submitting the letter. This paragraph and other italicized information within brackets are intended to provide additional guidance and should be omitted from the final letter. Healthcare providers should also consider using their organization's official letterhead. Remove this paragraph before use.]

[Date]
[Payer Medical or Pharmacy Director Contact/Name]
[Payer Organization Name]
[Payer Street Address]
[Payer City, State, ZIP Code]

RE: [Patient Name]
Date of birth: [Patient's Date of Birth]
Policy ID/Group number: [Policy ID/Group Number]
Policy holder: [Policy Holder's Name]

Dear [Payer Medical or Pharmacy Director/Contact Name],

I am [Physician Name, credentials, specialty, hospital/practice], and I am writing on behalf of my patient, [Patient Name], to document the medical necessity of [Doptelet® (avatrombopag)/Doptelet® Sprinkle (avatrombopag)].

[I plan to use Doptelet to treat thrombocytopenia in an adult patient with chronic liver disease (CLD) who is scheduled to undergo a procedure.]

[I plan to use Doptelet to treat thrombocytopenia in an adult patient with chronic immune thrombocytopenia (ITP) who has had an insufficient response to a previous treatment.]

[I plan to use Doptelet to treat a patient aged 6 years or older with persistent or chronic immune thrombocytopenia (ITP) who has had an insufficient response to a previous treatment.]

[I plan to use Doptelet Sprinkle to treat a pediatric patient aged 1 year to less than 6 years with persistent or chronic immune thrombocytopenia (ITP) who has had an insufficient response to a previous treatment.]

1. Patient-Specific Rationale for Treatment

In brief, I have determined that [initiating/continuing] treatment with [Doptelet/Doptelet Sprinkle] for [Patient Name] is medically appropriate and necessary. Outlined below are [Patient Name]'s medical history and prognosis, and the clinical rationale for treatment with [Doptelet/Doptelet Sprinkle]. The patient meets the following criteria for treatment: [List specific criteria here].

[Note: The following section is to be completed by the physician based on the patient's medical history and prognosis.]

2. Summary of Patient's Medical History and Support for Using [Doptelet/Doptelet Sprinkle] *[You may be required to include]*

- [Patient's diagnosis and current condition]
- [Relevant medical history and/or family history]
- [Previous therapies the patient has taken for persistent or chronic ITP]
- [Clinical notes, including response to therapy if patient is already on Doptelet or Doptelet Sprinkle]
- [Guidelines from The American Society of Hematology and the International Consensus Report to support use of a second-line treatment]
- [Include the scheduled date of procedure for the appropriate indicated use.]

3. [Doptelet/Doptelet Sprinkle] Dosing Information

[Note: Mention the starting or current dose for Doptelet or Doptelet Sprinkle. You may choose to include details from the Prescribing Information attached to the end of this sample letter.]

Please call my office at [telephone number] if you require additional information. I look forward to receiving your timely response and approval of this authorization.

Sincerely,
[Physician Name]
[Title, Institution]
[Email/Phone Number]

[Note: Attach full Prescribing Information.]