[Insert Physician Letterhead]

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

Re: Member Name: [Insert Member Name]
Member Number: [Insert Member Number]
Group Number: [Insert Group Number]

REQUEST: Authorization for treatment with TECVAYLI® (teclistamab-cqyv)
DIAGNOSIS: [Insert Diagnosis] [Insert ICD]
DOSE AND FREQUENCY: [Insert Dose & Frequency]
REQUEST TYPE: ☐ Standard ☐ EXPEDITED

Dear [Insert name of Medical Director or name of individual responsible for prior authorization]:

I am writing to [support my request for an **authorization**] or [request a **formulary exception**] for the above-mentioned patient to receive treatment with TECVAYLI® for [Insert Indication]. My request is supported by the following:

Summary of Patient's Diagnosis

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

Summary of Patient's History

[Insert:

- Previous therapies/procedures, including dose and duration, and response to those interventions
- Description of patient's recent symptoms/condition

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

Treatment Plan

- Describe medication drug, dose, frequency, and duration
- Site of medical service—include site type (eg, inpatient, hospital outpatient, outpatient clinic, private practice, or other) and rationale (eg, compliance or closely monitoring patients)

Rationale for Treatment

[Insert summary statement for rationale for treatment such as: Considering the patient's history, condition, and the full Prescribing Information supporting uses of TECVAYLI®, I believe treatment with TECVAYLI® at this time is medically necessary, and should be a covered and reimbursed service.]

[Insert rationale for not using drugs that are on the plan's formulary.]

[You may consider including documents that provide additional clinical information to support the recommendation for TECVAYLI® for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with TECVAYLI®]

Please provide a timely authorization. Contact my office at [Insert Phone Number or email] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]