Sample Letter of Medical Necessity

Health plans may request a Letter of Medical Necessity to support coverage of a drug product. The letter should explain why the drug is medically necessary for the specific patient and should reference evidence that supports appropriate use (eg, medical records, clinical treatment history, Prescribing Information, peer-reviewed literature).

The letter may be submitted as part of a prior authorization (PA) request or in response to a health plan's request for additional documentation to support approval of a PA.

- The letter must include patient-specific information, be written on the prescriber's letterhead, and be signed by the prescriber.

This **sample Letter of Medical Necessity** is provided for informational purposes only and is not based on legal advice or official guidance from health plans. Denali Therapeutics does not warrant, promise, guarantee, or make any statement that the use of this information will result in health plan coverage or reimbursement.

Questions? Denali Patient Services is available to help

Call 1-844-DNLI365 (1-844-365-4365)

8:30 AM to 8 PM ET, Monday–Friday (except holidays)

BELOW IS A TEMPLATE YOU CAN USE TO DRAFT YOUR LETTER OF MEDICAL NECESSITY

Sample Letter of Medical Necessity

[Date]

[Health plan name]

ATTN: [Health plan contact name]

[Health plan address]

[City, State ZIP]

Re: Letter of Medical Necessity for AVLAYAH (tividenofusp alfa-eknm)

Patient: [Patient's full name]

Date of Birth: [MM/DD/YYYY]

Subscriber ID #: [Insurance ID #]

Subscriber Group #: [Insurance Group #]

Case ID Number: [Case ID number (if available)]

Dear [Contact name],

I am writing on behalf of my patient, [Patient's full name], to request coverage for AVLAYAH (tividenofusp alfa-eknm).

I am a board-certified [role/specialty] and have been managing [Patient's first name]'s care for the past [# years/# months].

[Patient's first name] is [age] years old and was initially diagnosed with MPS II (E76.1) by [me or other Physician's name] on [date]. Based on my clinical assessment and experience with this condition, I strongly believe that AVLAYAH is medically necessary for [Patient's first name] for the following reasons:

[Provide rationale for why this therapy is medically necessary, such as:]

- [• Reasons why this treatment is appropriate for your patient (eg, efficacy/safety profile, mechanism of action)]
- [• Documentation of neurologic manifestations consistent with MPS II. These can include*†:
  - Cognitive impairment or developmental delay (eg, neuropsychological or developmental assessment)
  - Behavioral problems, including hyperactivity, impulsivity, attention deficit, aggression (eg, specialist evaluation documenting behavioral impairment)
  - Brain structural abnormalities, including hydrocephalus, white matter, corpus callosum (eg, brain MRI/CT report)
  - Seizures (eg, neurology consult note and/or EEG report)
  - Other relevant neurologic examination findings (eg, abnormal reflexes)]
- [• Clinical factors (eg, diagnosis, symptoms, disease activity, and relevant history)]
- [• Inadequate response or intolerance to prior therapies]
- [• Any health plan-specific documentation requirements]
- [• Additional clinical justification based on your medical judgment]

Below is a summary of [Patient's first name]'s clinical background, key laboratory results, treatment history, and other documentation to support the medical necessity for treatment.

Patient's Medical Summary

[• Test results confirming diagnosis of MPS II (eg, deficiency in iduronate 2-sulfatase enzyme activity as measured in fibroblasts or leukocytes combined with normal enzyme activity level of another sulfatase; or molecular genetic testing for deletion or mutations in the iduronate 2-sulfatase gene)]

[• Relevant laboratory findings (eg, urinary/CSF heparan sulfate, urinary glycosaminoglycans (uGAGs), other metabolic abnormalities)]

[• Documentation of neurologic manifestations consistent with MPS II. These can include**:
- Cognitive impairment or developmental delay (eg, neuropsychological or developmental assessment)
- Behavioral problems, including hyperactivity, impulsivity, attention deficit, aggression (eg, specialist evaluation documenting behavioral impairment)
- Brain structural abnormalities, including hydrocephalus, white matter, corpus callosum (eg, brain MRI/CT report)
- Seizures (eg, neurology consult note and/or EEG report)
- Other relevant neurologic examination findings (eg, abnormal reflexes)]

[• Clinical features (eg, respiratory complications, cardiac abnormalities, hearing loss, hepatosplenomegaly)]

[• Physical symptoms (eg, abdominal distension, coarse facial features, macroglossia, joint stiffness)]

[• Imaging and specialist evaluations (eg, EKG/ECHO, MRI, PFTs)]

[• Lack of efficacy from prior/current treatments (eg, ongoing or worsening somatic/neurological symptoms, other relevant laboratory findings)]

[• Refer to the health plan's medical policy for additional required documentation]

Site of Care (Optional Section)

After careful evaluation, I am requesting that treatment be provided through home infusion, as this setting is most appropriate for the following reasons:

[• My patient has successfully reached and tolerated the maintenance dose. In line with the US Prescribing Information, home infusion under the supervision of a qualified healthcare professional may be considered once this milestone is achieved.]

[• My patient is clinically stable and has not experienced side effects that would make home infusion unsafe or impractical.]

[• I believe the home infusion setting best supports my patient's medical needs, quality of life, and continuity of care.]

In my medical opinion—based on [Patient's full name]'s clinical history of MPS II, the accompanying documentation, and the therapeutic profile of AVLAYAH—this therapy represents the most appropriate and medically necessary treatment option for managing [Patient's first name]'s condition.

Thank you in advance for your immediate attention to this request for coverage reconsideration.
If you have any questions, please call me directly at [(###) ###-####].

Sincerely,

[Prescriber's Name, Credentials]

[Prescriber's Practice Name]

Enclosures:

[List and attach relevant documentation, such as:

Payer's prior authorization form, chart notes and medical records, genetic test results, laboratory test results, motor function assessment results, scans/images showing progressive disease, pathology reports, if relevant, Prescribing Information, FDA approval letter]

After you have completed the letter for your patient:

1. **Select "File" and select "Print":**
   - Instead of choosing a printer, select "Print to PDF" (or a similar option). In the printer settings, choose the PDF page range that only includes the letter (Note: Do not send the entire document as-is to the health plan. Selecting the PDF page range that only includes the letter will remove the instructions that are only intended for healthcare professional/office use)
   - Save the file using a unique patient identifier
   - Example: [LastName]_[Date]_Medical Necessity

2. **If you are uploading the letter:**
   - Go to the health plan's provider portal and login. Look for a section called "Claims" or "Forms." This is where you can upload the completed letter
   - Note: Remember to also attach any supporting documents you are including from the list of Enclosures on the final page of the letter and upload them together with the Medical Necessity letter

3. **If you are emailing the letter**:
   - Include the completed letter as an attachment in your email correspondence to the health plan
   - Note: Remember to attach any supporting documents you are including from the list of Enclosures on the final page of the letter and email them together with the Medical Necessity Letter

4. **If you are mailing the letter**:
   - Select "Print"
   - Note: Remember to print any supporting documents you are including from the list of Enclosures on the final page of the letter and mail them together with the Medical Necessity Letter

*These examples are illustrative and non-exhaustive; other evidence of neurologic manifestation consistent with MPS II may also be submitted.
†Neurologic manifestations in MPS II are described in Lau H, et al. *Mol Genet Metab Rep.* 2023;37:101005 and Yund B, et al. *Mol Genet Metab.* 2015;114(2):170-177. These may be referenced to support documentation as needed.