

—SAMPLE—

This letter is only intended as a **TEMPLATE Letter of Medical Necessity for BIXLENVO™**

INSTRUCTIONS: MUST BE ON HEALTHCARE PROVIDER'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HEALTHCARE PROVIDER. Please see the full Prescribing Information, including **BOXED WARNING**, at www.BIXLENVOhcp.com.

This sample letter is provided for your guidance only. It provides an example of the types of information that may be provided when responding to a request from a patient's insurance company to provide such a letter. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for the medication and is not intended to be a substitute for or to influence the independent medical judgment of the physician.

[Healthcare Provider's Stationery] [Insert Date]

[Medical Director] [Insurance Company] [Address] [City,
State ZIP]

RE: **Letter of Medical Necessity for [Product Name]**

Patient Name: [Insert Patient Name]

Policy Number: [Insert Policy Number]

Claim Number: [Insert Claim Number]

Subject: Letter of Medical Necessity for BIXLENVO

Dear [Insert Medical Director's Name]:

On behalf of my patient, [patient name], I am writing this letter to document the medical necessity of BIXLENVO for [INDICATION].

This letter serves to document my patient's condition and medical history, summarize my prescribing decision rationale, and provide a copy of the Prescribing Information for BIXLENVO.

[Name of patient] has maintained virologic suppression; however, continuation of the current regimen is **not clinically appropriate** due to [insert brief reason(s)].

[Provide a brief discussion of patient's history and current condition, laboratory results, adherence history, and supporting documentation, if applicable, highlighting those factors leading you to recommend the use of BIXLENVO].

BIXLENVO [was/will be] prescribed for [patient name] for [INDICATION].

[Conclusion statement regarding whether BIXLENVO is appropriate and reasonable for the patient.] Please contact me at [healthcare provider's telephone number] if you have any questions or if any additional information is required to ensure the prompt approval of this course of treatment.

Please see the full Prescribing Information for BIXLENVO at www.BIXLENVOhcp.com.

Sincerely,

[Healthcare Provider's Signature]

[Healthcare Provider Name] [Provider
Identification Number] [Phone
Number]

[Enclosures: List enclosures, which may include: BIXLENVO Prescribing Information, clinical notes, and any other relevant supporting documentation]

This sample letter is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical, or other advice. Use of this template or the information in this template does not guarantee reimbursement for coverage. Coverage and reimbursement may vary significantly by payer plan, patient, and other factors. The information provided is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional. Responsibility for ensuring the accuracy of information included in any communication between the healthcare provider and the payer remains solely with the healthcare provider.