BAXFENDY Letter of Medical Necessity

Template Instructions:

This template is offered as a resource that a healthcare provider could use when responding to a request from a patient's health benefits company to provide a letter of medical necessity for prescribing BAXFENDY™ (baxdrostat). As you review the template below, please note that you will need to populate or provide the information in bracketed blue font ([xxx]).

Documents typically included with the letter of medical necessity are a copy of the denial or explanation of benefits, any supporting documents, and Prescribing Information. If you have questions, please contact our Information Center at 1-800-236-9933.

Use of the Letter of Medical Necessity does not guarantee that the insurance company will approve your request for BAXFENDY™ and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

IMPORTANT NOTE: This template is intended to be completed by the patient's treating physician. Prior to submission, please delete these instructions and complete all sections below.

[Healthcare Provider Letterhead]

Date: [Month Date, Year]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, Zip Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Dear [Name of the Contact Person at the Payer]:

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of BAXFENDY™ (baxdrostat) for the treatment of [Specific Diagnosis]. This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale.

Patient History and Diagnosis
[Provide a Brief Description of the Patient's Medical Condition Here.]

[Include a Short Summary of the Patient's Medical History including lab results and failed medicines as applicable.]

[Explain why you believe it is Medically Necessary for the Patient to receive this Medicine.]

[Describe the Potential Consequences for the Patient if they do not receive this Medicine.]

[Obtain and Attach Supporting Letters from any other Specialist(s) that is currently or has previously provided Care to the Patient.]

[Include Medicine Indication Information.]

[Include Medicine Administration Information.]

To conclude, BAXFENDY is medically necessary in my professional opinion for this patient's medical condition. Please contact me at [Provider Phone Number] if any additional information is required to ensure the prompt approval of BAXFENDY for this patient.

Sincerely,

[Physician's Name]

[Physician's Practice Name]

Enclosures
[Include Indication and Important Safety Information]
[Include full Prescribing Information, including Patient Information for BAXFENDY]

References:

[Consider including BAXFENDY PI]

[Consider including other relevant references and publications regarding BAXFENDY]