

***NOTE: This Sample Letter of Medical Necessity is a template to help you write your own letter to health plans. Bracketed copy in blue font color is to be updated, reflecting relevant information for you, your practice, and your patient.***

SCEMBLIX Sample Letter of Medical Necessity

[Date]

[Medical Director’s name]

[Health plan]

[Address]

Re: [Patient’s name]

[Policy number, ID, group number]

[Date of Birth]

Dear [Medical Director’s Name/Other],

My name is [HCP name], and I am a [medical specialty] caring for [Patient's name], who is currently a member of [health plan]. I am writing to explain why, in my clinical judgment, SCEMBLIX® (asciminib) tablets is required for the treatment of this patient for [diagnosis and ICD-10 code]. [***If you are writing this letter for a formulary or tiering exception request, provide a statement of the exception you are requesting and the reason for the request.***] The following information supports my recommendation for treatment with SCEMBLIX:

**Summary of Patient's Medical History and Diagnosis**

**[*Include a summary of the patient's diagnosis and their current condition:*** Be sure to attach relevant medical records that support this information. While not exhaustive, the following topics are examples of information you may want to include:

* Patient’s diagnosis and date of diagnosis
* Documentation that other diagnoses have been excluded
* [Disease-state –specific] test results
* Measurement tool/scale results (if applicable)
* Persistent or troublesome disease aspects/symptoms (if applicable)
* Disease-specific documentation]

**Treatment History**

[***Include a summary of your patient's treatment history:***

* Provide a comprehensive list of previous therapies used, duration of therapy, and reason for discontinuation
* Specify which treatments the patient has tried and failed
* Confirm if the patient has not received adequate results from any previous treatment]

|  |  |  |
| --- | --- | --- |
| Previous therapy | Duration of therapy | Reason for discontinuation |
| [BRAND dose, frequency] | [days/weeks/months/years] | [Reason for discontinuation] |
| [BRAND dose, frequency] | [days/weeks/months/years] | [Reason for discontinuation] |

**Rationale for Treatment**

***[Provide your rationale for choosing* SCEMBLIX*:***

* Include clinical support for prescribing SCEMBLIX (This may be clinical trial data found in the SCEMBLIX Prescribing Information)
* Detail any of the patient's comorbidities that could serve as contraindications to certain other treatments
* Explain why the health plan's preferred therapies are not appropriate for your patient
* If your patient is already taking SCEMBLIX, describe their response to SCEMBLIX and explain why it is not in the best interest of your patient to switch therapies
* Provide your professional opinion of the patient's likely prognosis or disease progression without treatment with SCEMBLIX
* If you are writing this letter for an exception request, provide a statement of the patient’s financial hardship when appropriate]

Given [Patient's name] current condition and treatment history, I believe SCEMBLIX is the most medically appropriate and necessary therapy to treat [diagnosis] for

this patient. I have included the relevant medical notes supporting my recommendation. Please feel free to contact me, [HCP name, NPI number], by calling [office phone number] to answer any questions or participate in a peer-to-peer review discussing the necessity of SCEMBLIX for this patient. The coverage determination decision may be faxed to [HCP fax number] or mailed to [HCP business office address]. I look forward to your timely approval.

Sincerely,

[HCP name and signature]

[Specialty, name of practice, phone number]

Encl: [Medical records, SCEMBLIX® (asciminib) tablets Prescribing Information]



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