SAMPLE LETTER OF MEDICAL NECESSITY
FOR TURALIO® (pexidartinib) CAPSULES

To the prescribing healthcare provider: When determining if treatment with TURALIO is medically appropriate for a patient, please refer to the full Prescribing Information, including Boxed WARNING.

IMPORTANT NOTE:
The use of the information in this letter does not guarantee that the health plan will provide reimbursement for TURALIO and is not intended to be a substitute for or an influence on the independent medical judgment of the physician. Please make sure to review the health plan's instructions to determine whether additional enclosures, such as forms, chart notes, test results, and supporting literature, may also be necessary.

KEY REMINDER:
Translate this sample letter onto your physician's letterhead before printing.

[Date]

[Name]
[Insurance Company]
[Insurance Company Address]
[City, State, ZIP Code]
[Fax Number]

ATTN: Prior Authorizations/Appeals Department

Re: Coverage of TURALIO® (pexidartinib) capsules
[Patient First and Last Name]
[Insurance Policy Number]
[Insurance Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to substantiate the medical necessity of TURALIO for [Patient Name]. TURALIO® (pexidartinib) is indicated for the treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery. [Patient Name] has been diagnosed with symptomatic TGCT associated with severe morbidity and is not eligible for surgery; therefore, treatment with TURALIO is medically necessary and appropriate for this patient.

[Patient Name]’s medical history and previous and current treatments are consistent with the following:
[Insert description of the patient’s medical history as it pertains to treatment with TURALIO. Please include information on functional limitations/symptoms, including diagnosis, and test results; all previous and current treatment regimens, including any surgical procedures, and treatment outcomes; and patient’s likely prognosis without treatment with TURALIO.]

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The information I have provided above justifies that the use of TURALIO, [dose/frequency], is medically appropriate and necessary for [Patient Name]. Enclosed is a copy of [Patient Name]’s medical records, which document the diagnosis, treatments received, and proof of medical necessity. The full Prescribing Information for TURALIO is also enclosed, which serves to further substantiate the use of TURALIO for this patient.

I request that you please approve coverage of TURALIO for [Patient Name] as recommended. I appreciate your prompt consideration of this matter. If additional information is needed, I am happy to provide it to you.

Sincerely,
[Physician Name]
[NPI Number]
[Practice Name (if applicable)]
[Address]
[Phone Number]
[Fax Number]