[PRACTICE LETTERHEAD]

[Date]

[Dr/Mr/Ms] [Medical Director Name]
[Name of Health Insurance Company]
[Insurer Address]
[City], [State] [Zip Code]

Re: [Patient Name]
Policy Number: [ ]
Group Number: [ ]
Date of Birth: [MM/DD/YYYY]

Dear [Dr/Mr/Ms] [***Surname of Medical Director***]:

I am writing on behalf of my patient, [Mr/Ms] [***patient name***], to request coverage based on medical necessity for CINVANTI® (aprepitant) injectable emulsion, a substance P/neurokinin-1 (NK_1) receptor antagonist, indicated in adults, in combination with other antiemetic agents, for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin and nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC). CINVANTI has not been studied for treatment of established nausea and vomiting.

Rationale for treatment with CINVANTI
[***Patient name***] will receive [***insert the chemotherapy drug(s)***], which is/are considered emetogenic, for [***condition***]. Treatment with a substance P/NK_1 receptor antagonist is medically necessary and is recommended by NCCN and ASCO guidelines.[1,2] CINVANTI is an intravenously administered antiemetic that is proven equivalent to fosaprepitant for injection; it is a polysorbate 80–free injectable formulation of aprepitant.[3] Additionally, within the first 30 minutes of infusion, CINVANTI demonstrated a lower rate of treatment-emergent adverse events vs fosaprepitant, either as a 2-min IV push or a 30-min IV infusion.[4] The use of CINVANTI is appropriate for this patient, is expected to provide clinical benefits, and warrants approval for coverage.

The patient's medical history and treatment regimen are as follows:
[***Describe the patient's history, diagnosis, and current treatment regimen. Describe the anticipated outcome with* CINVANTI *and the anticipated outcome without this therapy. NOTE: Physicians should exercise their medical judgment and discretion in regard to making an appropriate diagnosis and characterization of an individual patient's medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.***]

In summary, I believe that CINVANTI is medically necessary and appropriate for [***patient name***] during chemotherapy. Please contact me at [***physician telephone number***] if you require any additional information to ensure the prompt approval of this course of treatment.

Sincerely,

[***Physician name***]
[***Physician signature***]

References: 1. National Comprehensive Cancer Network®, NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®). Antiemesis. Version 1.2021. https://www.nccn.org/professionals/physician_gls/pdf/antiemesis.pdf. Accessed April 23, 2021. **2.** Hesketh PJ, Kris MG, Basch E, et al. Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update. *J Clin Oncol.* 2017;35(28):3240-3261. **3.** CINVANTI [package insert]. San Diego, CA: Heron Therapeutics, Inc; October 2019. **4.** Ottoboni T, Lauw M, Keller MR, et al. HTX-019 via 2-min injection or 30 min infusion in cancer patients receiving emetogenic chemotherapy. *Future Oncology 2019; 15(8):865-874*