[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 SUSTOL® (granisetron) extended-release injection, J1627, for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic chemotherapy (MEC) or anthracycline and cyclophosphamide (AC) combination chemotherapy regimens.

Rationale for treatment with SUSTOL
[***Patient name***] will receive [***insert the chemotherapy drug(s)***], which is/are considered emetogenic, for [***condition***]. Treatment with a 5-hydroxytryptamine3 (5-HT3) receptor antagonist is standard of care and medically necessary. SUSTOL is a subcutaneously administered antiemetic that consists of granisetron, a selective 5-hydroxytryptamine3 receptor antagonist, incorporated in an extended-release polymer formation. The advanced, extended-release technology is designed to provide full 5-day chemotherapy-induced nausea and vomiting (CINV) prevention.[1] The use of SUSTOL 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 SUSTOL 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 SUSTOL 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. SUSTOL [package insert]. Heron Therapeutics, Inc., San Diego, CA; May 2017.