NOTE: This template is provided upon request for informational purposes. Please customize any letter you send to a payer to reflect the unique background and diagnosis of the particular patient, as well as the specific requirements of that payer. The physician is responsible for ensuring the accuracy of the information as it relates to your patient. Partner Therapeutics, Inc. does not guarantee coverage or reimbursement and is not responsible for the outcome of any appeals related to prior authorization or other benefits decisions. Coverage and appeal outcomes are determined solely by the insurance provider, based on their policies and criteria.

SAMPLE Letter of Appeal

To be placed on your letterhead

[Date]

[Payer Name]
[Payer Address]
[City, State, ZIP Code]
[Payer Fax Number]

Attn: [Payer Representative]
[Department Name (optional)]

Re: Coverage of BIZENGRI® (zenocutuzumab-zbco)
[Patient's First and Last Name]
[Policy Number / Patient's ID]
[Group Number]
[Patient Date of Birth]

[Case Ref#]

To Whom It May Concern:

This letter is in response to a denial received for prior authorization of services for coverage of BIZENGRI (zenocutuzumab-zbco) for my patient, [Patient First Name, Patient Last Name]. The request for prior authorization was denied as ***[insert appropriate reason for denial]***. It is my understanding that my patient is entitled to a Level 1 appeal for this adverse benefit determination. I also request that this appeal be reviewed by a physician, preferably a Medical Oncologist.

BIZENGRI® is a bispecific HER2- and HER3-directed antibody indicated for the treatment of:

- Adults with advanced, unresectable or metastatic non-small cell lung cancer (NSCLC) harboring a neuregulin 1 (*NRG1*) gene fusion with disease progression on or after prior systemic therapy*.
- Adults with advanced, unresectable or metastatic pancreatic adenocarcinoma harboring a neuregulin 1 (*NRG1*) gene fusion with disease progression on or after prior systemic therapy*.

*This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

CLINICAL HISTORY

[Patient First Name, Patient Last Name]'s medical history and course of treatment are as follows:

- **[Describe the patient's history, diagnosis, previous and current treatment regimens and *his/her* outcomes.]**

APPEAL

The denial for services is based upon the finding that ***[insert appropriate reason for denial]***.

Based on ***[Patient's Name]***'s condition, medical history, and supporting clinical literature, it is my professional opinion that the use of BIZENGRI is an appropriate therapeutic option for ***[him/her]*** at this time.

I respectfully request that you review the additional documentation provided and reconsider your coverage decision for BIZENGRI. I look forward to your reconsideration. If I can provide any additional information, please contact me at ***[insert phone number]*** to ensure the prompt approval of this course of treatment.

Please see accompanying full BIZENGRI Prescribing information including BOXED WARNING.

Regards,

[Physician Name]

W