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 benefit or coverage decisions. Coverage and appeal outcomes are determined solely by the insurance provider, based on their policies and criteria.

SAMPLE Letter of Medical Necessity

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:

I am writing on behalf of my patient, ***[Patient First Name] [Patient Last Name]***, to document the medical necessity of treatment with BIZENGRI® (zenocutuzumab-zbco).

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).

[Patient's 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.**

It is my professional opinion that ***[Patient's name]*** should receive BIZENGRI for the following reasons:

- **[List reasons]**

Based on the information provided above, BIZENGRI is an appropriate therapeutic option for ***[Patient Name]*** at this time. Enclosed are copies of ***[Patient's Name]***'s medical records documenting ***[his/her]*** disease and supporting medical necessity of this therapy. I respectfully request that you review the additional documentation provided and approve coverage for BIZENGRI on ***[Patient's Name]***'s behalf.

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.

Sincerely,

[Physician Name]