Sample Format Letter of Medical Necessity

[Insert physician letterhead]

[Name] RE: Member Name __________________

[Insurance Company/Payer Name] Member Number __________________

[Address] Group Number __________________

[City, State, ZIP]

EXPEDITED REQUEST: Authorization for Treatment with IMBRUVICA® (ibrutinib) capsules

Dear: [Insurance Company/Payer Name]

I am writing to make an expedited authorization request for my patient to receive treatment with IMBRUVICA® as per the labeled indication below [NOTE: select as applicable]:

A. Mantle Cell Lymphoma and has received at least one prior therapy
B. Chronic Lymphocytic Leukemia and has received at least one prior therapy
C. Chronic Lymphocytic Leukemia with del 17p
D. Waldenström's macroglobulinemia

This request is consistent with the Indications and Usage per IMBRUVICA® Prescribing Information that can be found at www.IMBRUVICA.com.

My request is supported by the following:

Summary of Patient History

You may want to include [NOTE: Exercise your medical judgment and discretion when providing a diagnosis characterization of the patient’s medical condition.]

- Patient’s diagnosis, date of diagnosis, stage, relevant labs, condition and history
- Previous therapies and procedures the patient has undergone for management of this condition
- Patient’s response to these therapies
- Summary of your professional opinion of the patient’s likely prognosis without treatment with IMBRUVICA®

Rationale for Treatment

Considering the patient’s history, condition, and information available in the IMBRUVICA® Prescribing Information, I believe treatment with IMBRUVICA® at this time is appropriate, and medically necessary. Given the urgent nature of this request, please provide an expedited authorization. Contact my office at [insert telephone number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and participating provider number]

Enclosures

01/15 PRC-00857