[Date]
[Appeals department]
[Name of health plan]
[Mailing address]

RE: [Patient name]
Policy number: [Policy number]
Claim number: [Claim number]
Subject: Supporting Coverage of YONSA® (abiraterone acetate)

Dear [Medical director],

This letter is sent on behalf of [patient's name] to document that he has been diagnosed with metastatic CRPC and requires treatment with YONSA® (abiraterone acetate). I am writing to document my patient's medical history and diagnosis and summarize my treatment rationale. Treatment with YONSA® (in combination with methylprednisolone) [dose, frequency] is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old male who was diagnosed metastatic CRPC on [date]. [Patient's name] has been in my care since [date].

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

Considering my patient's history, condition, and full Prescribing Information supporting the use of YONSA® I believe treatment with YONSA® (in combination with methylprednisolone) is appropriate, medically necessary, and should be covered and reimbursed. Enclosed you will find other relevant supporting documentation.

Please contact my office by calling [phone number] for any additional information you may require. Give the urgency of [patent's name] metastatic CRPC, I look forward to your timely approval.

Sincerely,
[Physician's signature]
[Physician's name]

Suggested enclosures:
Package insert for YONSA®
Copy of patient medical records
Other supporting documentation

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