[Insert Physician Letterhead]

[Insert Name of Medical Director] RE: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State Zip]

**REQUEST:** Authorization for treatment with ERLEADA™ (apalutamide)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to support my request for an **authorization** for the above-mentioned patient to receive treatment with ERLEADA™, [insert indication]. My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient History**

[Insert previous therapies/procedures, response to those interventions, description of patient’s recent symptoms/condition, summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment with ERLEADA™. Note: Exercise your medical judgement and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

Considering the patient’s history, condition, and the full Prescribing Information supporting uses of ERLEADA™, I believe treatment with ERLEADA™ at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service. Please see the accompanying [peer reviewed journal, supporting clinical guidelines, FDA approval letter and] full Prescribing Information for ERLEADA™ that provide additional clinical information to support my recommendation for ERLEADA™ for this patient.

Given the urgent nature of this request, please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

☐ If this request is denied, I am requesting an expedited Exception review by a professional in my specialty.

Enclosures [Include full Prescribing Information and the additional support noted above]