[TREATMENT CENTER LETTERHEAD]

[Payer/Insurance Company Name]

[Payer/Insurance Company Address]

[Contact Name]

[Title]

[Date]

**Re: Appeal of Denied Coverage for AUCATZYL® (obecabtagene autoleucel)**

|  |  |
| --- | --- |
| Plan Member | [Patient Name] |
| Date of Birth | [Patient Date of Birth] |
| Member ID  | [Member ID Number] |
| Member Group/Policy | [Member Group/Policy Number] |
| Denial Reference  | [Denied PA/Claim Number and Denial Date] |

To Whom It May Concern:

This letter is a formal request for an expedited appeal review by a hematologist advisor for reconsideration of denied coverage of AUCATZYL for [Patient Name] in the treatment of [patient’s diagnosis].

On [Denial Date], AUCATZYL coverage was denied by [Payer/Insurance Company Name] due to [reasons stated in the denial letter]. However, according to the clinical assessment and the supporting evidence summarized below, AUCATZYL is warranted, appropriate, and medically necessary for [Patient Name].

**Relevant Patient History**

|  |  |
| --- | --- |
| Diagnosis | [Primary diagnosis and associated ICD-10-CM code(s)] |
| Disease Characteristics | [Relevant histology, disease burden measures, and/or prognostic factors] |
| Prior Treatment | [Prior regimen(s), including timing and response] |
| Clinical Fitness  | [Relevant indicators of organ function and/or performance status] |

**AUCATZYL Treatment Plan**

|  |  |
| --- | --- |
| Treatment Process | [Key treatment process phases and planned treatment schedule] |
| Product Administration | [Product administration schedule and number of infusions] |
| Site of Care  | [Treatment Center Name] is designated by Autolus as an Authorized Treatment Center for AUCATZYL |

**Supporting Evidence:**

|  |
| --- |
| [Summary of relevant evidence from Prescribing Information, treatment guidelines, recognized compendia, peer-reviewed literature, patient chart notes and medical records] |

Please note that any postponement in authorization of coverage can result in treatment delays. In the absence of this medically necessary treatment, the patient can succumb to the disease.
I look forward to receiving your timely response and reconsideration of this request.

Sincerely,

[Provider Name and Signature]

[NPI Number and Contact Information]

[Treatment Center Name and Address]

Enclosures:

[List of attached documents as appropriate, for example: FDA approval letter, Prescribing Information, publications referenced above, clinical documentation per patient record]

US-AUC-0043 10/24 V1