[TREATMENT CENTER LETTERHEAD]

[Payer/Insurance Company Name]

[Payer/Insurance Company Address]

[Contact Name]

[Title]

[Date]

**Re: AUCATZYL® (obecabtagene autoleucel) Medical Necessity Documentation**

|  |  |
| --- | --- |
| Plan Member | [Patient Name] |
| Date of Birth | [Patient Date of Birth] |
| Member ID  | [Member ID Number] |
| Member Group/Policy | [Member Group/Policy Number] |

To Whom It May Concern:

This letter is a formal request to document medical necessity of AUCATZYL for [Patient Name] in the treatment of [patient’s diagnosis].

**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 |

A clinical assessment of [Patient Name] indicates that AUCATZYL is medically necessary. In addition, the following evidence supports the rationale for treatment.

* [Summary of relevant evidence from Prescribing Information, treatment guidelines, recognized compendia, and/or peer-reviewed literature]

If you have further questions regarding the patient’s medical history, previous treatments, or this request, please do not hesitate to contact me.

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]

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