Sample Letter of Authorization: This sample letter is for demonstration purposes only. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for or to influence the clinical decision making of the prescribing healthcare professional.

[Insert Physician Letterhead]

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

[Insert Payer Name] Member DOB: [Insert Member DOB]

[Insert Address] Member Number: [Insert Member Number]

[Insert City, State, Zip] Group Number: [Insert Group Number]

 Reference Number: [Insert Reference Number]

 Date(s) of Service: [XX/XX/XXXX]

**REQUEST:** Request for Formulary Exception forCAMZYOS® (mavacamten)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD-10 Code]

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

Dear [Insert Name of Medical Director]:

I am writing to request a **formulary exception** for the above-mentioned patient to receive treatment with CAMZYOS® for [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’s History**

You may consider including the following information:

* Description of patient’s symptoms associated with symptomatic obstructive HCM
* Signs of obstructive HCM observed via echocardiograms
* Relevant comorbidities
* Previous and/or current treatments for obstructive HCM and response to those interventions
* Rationale for not using drugs that are on the plan’s formulary
* Summary of your professional opinion of the patient’s likely prognosis or potential disease progression without treatment with CAMZYOS®

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Insert summary statement for rationale that CAMZYOS is medically necessary and should be covered and reimbursed]

[You may consider including documents that provide additional clinical information to support the recommendation for CAMZYOS® for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Please contact me at [Insert Phone Number] should you have questions or need additional information. Thank you for your time and immediate attention to this request.]

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosures [If choosing to include full Prescribing Information and/or any of the additional supporting documents noted above, please list and attach those documents here]