**[Physician Letter Head]**

**Note: This sample letter is provided as a courtesy and is not meant to be directive.**

**[Date]**

**[Payer Contact]**

**[Title/Pharmacy Director]**

**[Payer Company]**

**[Payer Address]**

**[City, State, ZIP]**

RE: Letter of Medical Necessity for VONJO® (pacritinib) capsules

Insured: **[First and Last Name]**

Patient: **[If different from insured]**

ID/Policy Number: **[Insured ID/Policy #]**

Group Number: **[Insured Group #]**

Patient Date of Birth: **[Patient Date of Birth]**

Dear **[Name of Payer Contact / Pharmacy Director]**:

I am writing on behalf of my patient, **[Patient Name]**, to document the medical necessity for treatment with VONJO. **[Patient Name]** is an adult who has **[Diagnosis]**. This letter outlines **[Patient Name]**’s medical history and treatment needs.

**Summary of Patient’s History [Below are some points you may want to include regarding patient’s medication condition]:**

* **Patient’s diagnosis, condition, and medical history, including relevant test results
and ICD-10-CM codes**
* **Previous therapies that patient has undergone for this diagnosis, including dates and duration of therapy**
* **Patient response rate to these therapies, including lab values that indicate disease progression or treatment failure**
* **Brief description of the patient’s recent symptoms and condition**
* **Summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment**
* **Be sure to include documentation that supports why you feel [treatment] is clinically appropriate and could be beneficial [disease management]**
* **Resources that you may want to include to justify pacritinib (VONJO) as a therapy option for your patient:**
	+ **NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)1 via** [**NCCN.org**](http://www.nccn.org)
	+ [**PERSIST-2 data**](https://jamanetwork.com/journals/jamaoncology/fullarticle/2674384)

**Rationale for Treatment**

Given the patient’s history and condition, I believe treatment with VONJO is warranted, appropriate, and medically necessary.

The attached provides the safety and efficacy of VONJO in adult patients with **[Diagnosis]**.

I confirm that I have reviewed the VONJO prescribing information and am aware of the indication, the important safety information, and how to prescribe VONJO.

Please call my office at **[insert telephone number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

**[Insert Doctor name and participating provider number]**

NCCN=National Comprehensive Cancer Network® (NCCN®).

**Reference: 1.** Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Myeloproliferative Neoplasms V.3.2022. © National Comprehensive Cancer Network, Inc 2022. All rights reserved. Accessed August 11, 2022. To view the most recent and complete version of the guidelines, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

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