Yutrepia™ (treprostinil) inhalation powder

SAMPLE LETTER OF MEDICAL NECESSITY

Dear Clinician,

Enclosed is a sample Letter of Medical Necessity to serve as a template if your patient's health plan has prescribing requirements or limitations for YUTREPIA™ (treprostinil) inhalation powder, such as a prior authorization, step therapy, or does not include YUTREPIA on its formulary. This template includes prompts for the information your patient's insurance company will expect when evaluating treatment necessity.

This template is a sample of what can be submitted as a comprehensive and impactful appeal so your patient can receive authorization and begin treatment as soon as possible. Because every plan has its own medical exception process, the required information may vary, and additional supporting evidence may be required.

Leave blank or enter "N/A" in any field that is not pertinent to your appeal. The letter should be sent on your office letterhead. You can either insert your business logo in the fields provided, or print the letter directly onto your official letterhead. You may also draft and submit a different Letter of Medical Necessity if you prefer.

This template is provided as an example and is intended to be tailored to each prescriber and patient. This letter is not a guarantee of insurance coverage or reimbursement. It is the sole responsibility of the health care provider to include the proper information and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient.

Sincerely,

Your Liquidia Team

Liquidia™

[Date]

[Health Plan Name]
[Health Plan Contact Name]
[Health Plan Address Line 1]
[Health Plan Address Line 2]

Patient Name:
Patient Date of Birth: [mm/dd/yyyy]
Policyholder Name:
(if different from Patient)
Subscriber/Member ID #:
Group ID #:

Re: Medical Necessity for treatment with YUTREPIA™ (treprostinil) inhalation powder

Dear [Medical Director Name],

I am writing on behalf of my patient, named above, to request you approve coverage for the use of YUTREPIA™ (treprostinil) inhalation powder as a medically necessary treatment for [Specific diagnosis]

This letter documents the medical necessity for use of YUTREPIA for my patient and provides information about their medical history, treatment and relevant test results.

INDICATION

YUTREPIA is a prostacyclin mimetic indicated for the treatment of:

- Pulmonary arterial hypertension (PAH; WHO Group 1) to improve exercise ability. Studies establishing effectiveness predominately included patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%).
- Pulmonary hypertension associated with interstitial lung disease (PH-ILD; WHO Group 3) to improve exercise ability. The study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia (IIP) (45%) inclusive of idiopathic pulmonary fibrosis (IPF), combined pulmonary fibrosis and emphysema (CPFE) (25%), and WHO Group 3 connective tissue disease (22%).

On the following page, I provide detailed information in support of my request for your consideration. Given the nature of this request, I kindly ask for a timely review and authorization.

If I can provide any additional information, please contact my office at the number below.

Sincerely,
[Prescriber Name]

Phone:
Fax:

Summary of my patient's diagnosis

Patient Name: **Age:** **Gender:**
Diagnosis: [specific diagnosis] **WHO Group:**
ICD-10: **Date of diagnosis:** **NYHA functional class**:

Patient's medical history:

Patient's current condition:

Previous therapies and/or procedures and patient's response:

Current PAH therapies and/or procedures and patient's response:

Tests and results:

- ◯ Right heart catheterization: [RHC result]
- ◯ Echocardiogram: [Echocardiogram result]
- ◯ 6-minute walk test: [6MWD result]
- ◯ High-resolution CT scan: [High-res CT scan result (may be required for PH-ILD)]
- ◯ [Other test] : [Other test result]

Rationale for treatment

[example] I have taken great consideration regarding the patient's current condition and prognosis. I believe treatment with YUTREPIA™ (treprostinil) inhalation powder is medically necessary at this time and should be a covered treatment option for this patient.

Treatment plan:

Supporting documentation:

- ◯ The full Prescribing Information of YUTREPIA™ (treprostinil) inhalation powder. Provided clinical information that played a key part in making my determination that this is the appropriate treatment.

I have also included the following additional documentation to further support my recommendation to treat this patient with YUTREPIA:

- ◯ Diagnostic Test Results
- ◯ Pathology Reports
- ◯ Clinical Notes / Records
- ◯ Medical Scans
- ◯ [Other enclosure 1]
- ◯ [Other enclosure 2]

Prescriber Name: NPI #:

Prescriber Signature:_____
Date: