**FOR INFORMATIONAL USE ONLY**: This is a Sample Letter of Medical Necessity. It is not intended to substitute for your medical judgment when providing a diagnosis of the patient’s medical condition or recommendation for a particular treatment. Please transfer this sample letter onto your practice’s letterhead before printing.

[Month day, year]

ATTN: [Medical Director]

[Payer name]

[Payer contact name]

[Payer address]

Re: Letter of Medical Necessity for ROMVIMZA™ (vimseltinib)

Patient: [Patient’s first and last name]

Subscriber ID#: [Insurance ID #]

Group #: [Insurance group #]

Dear [Medical Director],

I am writing on behalf of my patient, [Patient name], to document the medical necessity for treatment with ROMVIMZA. Based on my experience in managing tenosynovial giant cell tumors (TGCT), I believe ROMVIMZA is medically necessary and appropriate for my patient. This letter provides information about the patient’s medical history and diagnosis, and a statement summarizing my treatment rationale. On behalf of the patient, I am requesting approval for the use of, and subsequent payment for, the treatment.

# Patient History and Diagnosis

[Patient name] is [a/an] [age]-year-old [male/female] who was diagnosed with [ICD- 10 code] [diagnosis name] on [month day, year]. As a result of [diagnosis], my patient [enter a brief description of patient history]. Additionally, [Patient name] has tried [state previous surgeries and/or therapies] and [state outcomes]. [Patient’s name] likely prognosis without treatment with ROMVIMZA is [insert a summary of patient’s prognosis].

Please see the enclosed documentation that provides my patient’s medical history and supporting information relating to my request to treat [Patient name] with ROMVIMZA.

# Treatment Information

ROMVIMZA is a kinase inhibitor indicated for treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) for which surgical resection will potentially cause worsening functional limitation or severe morbidity

The safety and efficacy profile of ROMVIMZA makes it a necessary and appropriate option for [Patient name]. [Include any additional clinical rationale explaining the medical necessity of this.]

# Supporting Documentation

The following items are enclosed [Note: The below items are suggested enclosures and anything not applicable can be deleted]:

* [Package Insert for ROMVIMZA]
* [ICD-10 code, diagnosis name, and dates]
* [Any applicable testing, pathology, and/or imaging results that support TGCT diagnosis and appropriateness of treatment with ROMVIMZA]
* [History of past surgeries, treatments and/or failed treatment(s) outcomes, e.g., pain/steroid medication, Turalio® (pexidartinib), imatinib, Tasigna® (nilotinib)]

Please consider the coverage of ROMVINZA on [patient name]’s behalf and approve the use and subsequent payment for ROMVIMZA. If you have any further questions regarding this matter, please do not hesitate to call me at [Physician’s phone number]. Due to the physical impact on my patient from TGCT, I’d like to thank you for your prompt attention to this matter.

Thank you very much for your time and consideration.

Sincerely,

[Physician’s signature]

[Physician’s name and credentials]