[SAMPLE TEMPLATE:
Letter of Medical Necessity for the use of
LUPKYNIS™ (voclosporin) for lupus nephritis]

A patient-specific letter of medical necessity is generally required to appeal a denied prior authorization for medication coverage. The purpose of the letter is to explain the physician's reasons for selecting a particular therapy. This sample templated letter of medical necessity contains suggested content with fields that can be filled in and customized based on your patient's personal and medical history. *Note that some health plans have specific requirements for documenting medical necessity. Please check with your patient's health plan to be certain you are providing all required documentation.*

IMPORTANT NOTE: Use of the Letter of Medical Necessity template does not guarantee that the health plan will approve your request for LUPKYNIS and is not intended to be a substitute or an influence on the independent medical judgment of the healthcare provider.

Date:	RE: Patient Name: [_____]
[Name of Prescriber]	Policy Number: [_____]
[Health Plan]	Claim Number: [_____]
[Address]	Diagnosis: [_____]
[City, State, ZIP]	ICD-10-CM Code: [_____]

[Note: This appeal letter should be written on practice letterhead after fully reviewing the health plan's denial letter and medical policy for LUPKYNIS.]

Dear **[Health Plan]**:

I am writing on behalf of **[patient name]** to document the medical necessity of LUPKYNIS™ (voclosporin). LUPKYNIS is indicated in combination with a background immunosuppressive therapy regimen for the treatment of adult patients with active lupus nephritis (LN). The treatment of **[patient name]** with LUPKYNIS is supported by the following information.

1. Patient medical history and diagnosis
[This section to be completed by the physician based on the patient's medical history and prognosis. Be sure to include all information required by the health plan's medical policy.]

[Diagnosis and current condition, including date of last evaluation]

[Relevant medical history, including laboratory results]

[Previous therapies the patient has undergone for the symptoms associated with his or her disease]

[Patient response to these therapies *(including intolerable side effects, inadequate response, contraindications, and/or other considerations)*]

2. Rationale for treatment
[Explain why you believe it is medically necessary for the patient to receive LUPKYNIS. Describe the potential consequences to the patient if they do not receive LUPKYNIS.]

Based on the clinical data available to date, it is my medical opinion that treatment with LUPKYNIS for **[patient name]** is medically appropriate and necessary.

If you have any further questions or if any additional information is required, please contact my office at **[XXX-XXX-XXXX]**. Thank you for your attention to this matter, and I look forward to receiving your response.

Sincerely,

[Physician Name]
[Physician ID Number]

[Enclosures:]
[LUPKYNIS Prescribing Information]
[Patient medical records]
[Other relevant materials and supporting documents]