**Universal Letter of Medical Necessity/Overcome Denial**

**Disclaimer:** For your independent consideration and review, please make any and all changes that you believe appropriate, or disregard these suggestions in their entirety. The treating physician in his or her medical judgment is ultimately responsible for the accuracy, truthfulness, and completeness of all claims and communications submitted to third-party payers. Nothing in this document should be construed as a guarantee by Stemline Therapeutics, Inc. regarding coverage or payment by any payor at any specific level, and Stemline Therapeutics, Inc. does not advocate or promote the appropriateness of the use of any particular code. This form letter is intended for prior authorization/appeals purposes, not for promotional purposes. Please see the **ELZONRIS™ (tagraxofusp-erzs) Injection for Intravenous (IV) Use** FDA-approved label for information relevant to any prescribing decisions.

[Insert date]

RE: [Patient name]

[Patient insurance ID number]

[Insurance group #]

[Patient date of birth]

Dear [health plan contact name]:

I am writing on behalf of my patient, [insert patient name], to document the medical necessity of **ELZONRIS Injection for IV Use.**

This letter provides information about my patient’s medical history, diagnosis, and a summary of my treatment rationale.

**Patient’s Diagnosis:**

My patient has been diagnosed with [blastic NK-cell lymphoma/blastic plasmacytoid dendritic cell neoplasm (BPDCN): ICD-10 code C86.4].

**Patient’s Background:**

[Provide a brief description of the high unmet need in BPDCN, including significant delays from symptom onset to final diagnosis]

[If applicable, include a list of previous misdiagnoses]

Please also note that:

• I have been working with my patient since [insert date]

• I have prescribed [ELZONRIS Injection for IV Use] to treat this patient’s [BPDCN]

• [Overcoming denied claim option] The claim for [ELZONRIS Injection for IV Use] was denied for treatment dates: [insert treatment period in question]

**Why ELZONRIS Injection for IV Use:**

[Based on your clinical judgment, summarize why your patient requires treatment with ELZONRIS Injection for IV Use]

Therefore, I am prescribing [ELZONRIS Injection for IV Use] [and request coverage] for my patient because I have concluded that it is the most appropriate therapeutic option for this patient. Please review the clinical information I have submitted, which supports the diagnosis of [BPDCN] and my decision to prescribe [ELZONRIS Injection for IV Use].

Please feel free to contact me if you require further information regarding this request, and I look forward to your response as soon as possible.

Sincerely,

[Signature]

[Name]

**INDICATION**

ELZONRIS is a CD123-directed cytotoxin for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients 2 years and older.

**Boxed WARNING: CAPILLARY LEAK SYNDROME**

**Capillary Leak Syndrome (CLS), which may be life-threatening or fatal, can occur in patients receiving ELZONRIS. Monitor for signs and symptoms of CLS and take actions as recommended.**