[Insert Physician Letterhead]

[Insert Name of Medical Director] RE: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State ZIP]

**REQUEST:** Authorization for treatment with AKEEGA™ (niraparib/abiraterone acetate)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director or name of individual responsible for prior authorization]

I am writing to support my request for an **authorization** for the above-mentioned patient to receive treatment with AKEEGA™ for [insert indication]. I am writing on behalf of this patient who has been diagnosed with BRCA-mutated mCRPC. My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient History**

[Insert comorbidities if any/other medical conditions, previous therapies/procedures, response to those interventions, description of patient’s recent symptoms/condition, summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment with AKEEGA™. Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Considering the patient’s history, condition, and the full Prescribing Information supporting uses of AKEEGA™, I believe treatment with AKEEGA™ at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service. Please see the accompanying clinical information for this drug combination; supporting clinical guidelines; FDA approval letter; and full Prescribing Information for AKEEGA™ that provide additional clinical information to support my recommendation for AKEEGA™ for this patient.]

[Consider including this section if the patient has a history of adherence challenges which could impact outcomes, and a dual action tablet (DAT) may help this.] [We have been treating this patient for [amount of time] and have noted a consistent challenge with managing previously prescribed therapeutic regimens. We believe this is due in part to the patient’s comorbidities [list comorbidities here as relevant] as well as the burden associated with polypharmacy. The number of pills required for AKEEGA™ may be fewer than what is required for each of the other treatment options available for this patient. We believe that the reduced pill burden with AKEEGA™ may make the treatment regimen more manageable for this patient.]

[Given the urgent nature of this request], please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

☐ If this request is denied, I am requesting an expedited Exception review by a professional in my specialty.

Enclosures [Include full Prescribing Information and the additional support noted above]