[Date]

[Medical Director]

[Payer Name]

[Address]

[City, State Zip]

Re: [Patient Name]

[Patient Policy Number]

[Claim Number]

[Date(s) of Service]

Dear Sir or Madam:

I am writing to provide additional information to support my claim for the treatment of [Patient Name] with UDENYCA™ (pegfilgrastim-cbqv).

In brief, treatment of [Patient Name] with UDENYCA™ is medically appropriate and necessary, and should be a covered and reimbursed service. This letter outlines [Patient Name]’s medical history, prognosis, and treatment rationale.

**Summary of Patient’s History**

You may want to include

* Patient’s diagnosis, condition, and history
* Previous myelosuppressive anticancer therapies the patient has been treated with
* Patient’s response to these therapies, including infections and febrile neutropenia
* Brief description of the patient’s recent symptoms and conditions
* Summary of your professional opinion of the patient’s likely prognosis without UDENYCA™ treatment

(NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.)

**Rationale for Treatment**

Given the patient’s history, condition, and the published data supporting use of UDENYCA™, I believe treatment of [Patient Name] with UDENYCA™ is warranted, appropriate, and medically necessary.

The attached full prescribing information provides the approved clinical information for UDENYCA™.

Please call my office at [Phone Number] if I can provide any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Physician Name]

[Participating Provider Number]

Enclosures [Attach additional supporting documents (such as patient’s treatment with UDENYCA™, medical history, diagnosis, lab results, and treatment plan).]

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