

[Insert Physician Letterhead]

[Insert Name of Payer 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 TALVEY™ (talquetamab-tgvs)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD-10]

**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** or request a **formulary exception**] for the above-mentioned patient to receive treatment with TALVEY™ for [Insert Indication]. 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's History

[Insert:

- Previous therapies/procedures, including dose and duration, and response to those interventions
- Description of patient's recent symptoms/condition

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

### Treatment Plan

- Describe medication drug, dose, frequency, and duration
- Site of medical service—include site type (eg, inpatient, hospital outpatient, outpatient clinic, private practice, or other) and rationale (eg, compliance or closely monitoring patients)

### Rationale for Treatment

[Insert summary statement for rationale for treatment such as: Considering the patient's history, condition, and the full Prescribing Information supporting uses of TALVEY™, I believe treatment with TALVEY™ at this time is medically necessary, and should be a covered and reimbursed service.]

[Insert rationale for not using drugs that are on the plan's formulary.]

[You may consider including documents that provide additional clinical information to support the recommendation for TALVEY™ for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with TALVEY™]

Please provide a timely authorization. Contact my office at [Insert Phone Number or email] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

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