This letter is only intended as a SAMPLE Letter of Medical Necessity
For ZEMDRI® (plazomicin) injection
INSTRUCTIONS: MUST BE ON PROVIDER'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE PROVIDER

<Date>

<Rx Plan Name> <Rx Plan Fax Number>
<Rx Plan Representative>
<Rx Plan Address>
<City>, <State>, <ZIP Code>

ATTENTION: <Rx Plan Representative>
ATTENTION: <Department Name>

Re: **Medical Necessity Determination for ZEMDRI ®(plazomicin) injection use**
Patient Name: <Patient's Name>
Policy ID Number: <Patient's Policy No.> **Provider/Medicare Number**: <Provider/Medicare No.>
Date of Birth: <MM>/<DD>/<YYYY>
Physician's Name: <Physician's Name> **Physician's Phone Number**: <Physician's Phone No.>

Dear <Medical/Pharmacy Director Name and/or Medical Review/Appeals>:

I am writing on behalf of <Patient's Name> (<Policy Number>) to document the medical necessity of ZEMDRI for the treatment of <Indication from Prescribing Information>. The full prescribing information, including **BOXED WARNINGS**, for ZEMDRI can be found at www.ZEMDRI.com.

My patient suffers from <Patient's Diagnosis> and is currently experiencing the following <Patient's Symptoms>. Previous treatment regimens that have been used to treat <Patient's Name> include:

Therapy: _____
Dose: _____
Timeframe: _____
Outcome: _____

<Patient's Name>'s current condition is <list the clinical reasons that have led to the decision to initiate or continue therapy. In this rationale, include a description of the patient's disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>.

As a result, I am recommending the following ZEMDRI treatment for <Patient's Name>:

<Recommended Dose>
<Length of Treatment: It is best to be specific as not all payers accept indefinite treatment periods.>

In summary, ZEMDRI is medically necessary and reasonable for <Patient's Name>'s medical condition. Please contact me if you have any questions or if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,

<Physician's Name>
<Title>

ATTACHMENTS TO CONSIDER:

- ZEMDRI approved Prescribing Information
- Patient clinical notes and any other relevant supporting documentation

