SAMPLE Letter of Medical Necessity
For Vectibix® (panitumumab)

Date

Payor Name
Payor Representative
Payor Address
City, State, ZIP Code
Payor Fax Number

Attn: Payor Representative
Attn: Department Name (optional)

Re: Coverage of Vectibix® (panitumumab)
Subscriber's First and Last Name
Patient's First and Last Name
Policy # / Patient's ID
Group #
Patient Date of Birth
Patient Age
Patient Sex

Dear (Salutation) Medical or Pharmacy Director:

I am writing on behalf of ***{patient name}***, ***{policy number}*** to document the medical necessity of Vectibix® (panitumumab).

Vectibix® (panitumumab) is indicated as a single agent for the treatment of epidermal growth factor receptor (EGFR)-expressing, metastatic colorectal carcinoma (mCRC) with disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens. The full prescribing information, including **Boxed WARNINGS**, for Vectibix® can be accessed at www.vectibix.com.

Mr/Mrs/Ms ***{patient's last name}***'s medical history and course of treatment are as follows:

- **Describe the patient's history, diagnosis, previous and current treatment regimens and their outcomes.**

In my clinical opinion, Mr/Mrs/Ms ***{patient's last name}*** should receive Vectibix® for the following reasons.

- **List reasons**

In summary, Vectibix® is medically necessary and reasonable for Mr/Mrs/Ms ***{patient's last name}***'s medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,

{Physician Name}