This letter is only intended as a SAMPLE Letter of Medical Necessity
For ZYDELIG® (IDELALISIB)
MUST BE ON PROVIDER'S LETTERHEAD

Date

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

Attn: Rx Plan Representative
Attn: Department Name (optional)

Re: Tier exception for ZYDELIG (IDELALISIB) tablets use
Patient's Name:
Policy # / Patient's ID Group or Medicare #
Date of Birth Sex:
Physician's name:
Physician's phone number:

Dear (Salutation) Medical or Pharmacy Director:

I am writing on behalf of Patient's name, Policy number to document the medical necessity of ZYDELIG for treatment of_____. The full prescribing information, including **BOXED WARNING**, for ZYDELIG can be found at gilead.com.

My patient suffers from _____and is currently experiencing the following _____. 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).

As a result, I am recommending the following ZYDELIG 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, ZYDELIG is medically necessary and reasonable for Patient's name's medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment. Should you have any questions, please do not hesitate to call me at (phone number)

Sincerely,
(Physician Name), (Title)

GILEAD