

### Sample medical exception letter

You can use the sample medical exception letter on the next page if prescribed medication is not included in a health plan's written medical policy or is subject to a National Drug Code block.

Some health plans require a medical exception letter along with supporting documentation\*, such as:

- Patient medical records
- Supporting clinical studies
- Patient photographs
- Letter of medical necessity

\*To avoid any delays in reimbursement, it is recommended to provide as much documentation as possible.

It is important to note that supplying the above information does not guarantee the health plan will provide reimbursement for the prescribed medication. The sample letter is provided for your guidance only; it is not intended to influence or substitute for your independent medical judgment.

For any questions or concerns, or to report side effects with a Sanofi Genzyme product for patients enrolled in the CareASSIST Patient Support Program, please contact CareASSIST at 1-833-930-2273, Monday-Friday, 9 AM-8 PM Eastern Time.

Sanofi Genzyme is committed to protecting the confidentiality of individuals' personal healthcare information. This letter may contain personal healthcare information and should only be viewed by the individual to whom it is addressed. Please contact CareASSIST at 1-833-930-2273 if you believe you have received this letter in error.

## Sample medical exception letter

[Use physician's letterhead]

[Date]

[Health Plan Contact Name]

[Title]

[Health Plan Organization Name]

[Address]

[City, State, ZIP]

Re: [Patient Name], Insurance Policy ID Number: [Policy ID Number], Group Number [Group Number],  
Claim Number: [Claim Number]

Dear [Health Plan Contact Name],

I am writing to request a medical exception for [Patient full name] for the treatment of [insert diagnosis] with [PRODUCT]. It is my professional opinion that [PRODUCT] is medically appropriate and necessary and should be covered and reimbursed for this patient.

[Patient full name] has been under my care for [insert diagnosis] since [date of onset/diagnosis]. Included for your consideration is [Patient first name]'s medical history and diagnosis (ICD-10-CM code: [insert code]), a statement summarizing my reasons for treating [Patient full name] with [PRODUCT], and a copy of the Prescribing Information for [PRODUCT].

[Insert summary of patient history, including treatment history, response to past therapies, and recent symptoms and conditions.]

In summary, it is my professional judgment that it is in the best interest of [Patient full name] to be treated with [PRODUCT], and I am requesting approval for treatment with [PRODUCT]. Please call me at [phone number] if I can be of further assistance or if you require additional information.

Sincerely,

[Physician's name, degree(s), and signature]

Enclosures: [Attach any additional documentation, as appropriate]