[Physician’s Letterhead]

[Date]

[Name of Health Insurance Company]

[PO Box or Street Address]

[City], [State] [Zip Code]

Re: [Patient Name]

Policy #: [ ]

Group #: [ ]

To Whom It May Concern:

[Patient Name] is a patient under my care for [disease]. [He/She] was first diagnosed with [diagnosis] on [date of diagnosis]. [Provide description of treatment and/or surgery that followed the diagnosis].

At this time, I plan to start [Patient Name] on a course of treatment with [name of chemotherapeutic agent], known to be emetogenic, and [**CHOOSE FORMULATION**: AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) injection, liquid solution **OR** AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) for injection, lyophilized powder].

[Patient Name] will be treated with [state dosing regimen].

Without preventative treatment, [Patient Name] may experience [state complication(s)] related to [his/her] chemotherapy treatment. In my professional opinion, AKYNZEO® is medically necessary and an appropriate drug for my patient at this time. Enclosed is the US Prescribing Information for AKYNZEO®.

Also enclosed you will find the patient’s [list pertinent enclosures such as prior failed medication, chemotherapy flow sheets, and chart notes]. Please feel free to contact me if you require additional information.

Sincerely,

[Physician Name, Signature]

Enclosures:

• AKYNZEO® US Prescribing Information

• Patient medical records [list pertinent enclosures such as prior medication, chemotherapy flow sheets, and chart notes]

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