[Date]

[Medical Director]

[Payer Name]

[Address]

[City, State Zip]

Re: Medical Necessity for CIMERLI™ (ranibizumab-eqrn) injection

[Patient Name]

[Patient Date of Birth]

[Patient Policy Number]

Dear [Medical Director]:

I am writing on behalf of my patient (Patient Name) to provide information to support the medical necessity of CIMERLI™, which is indicated for:

* (Insert indication 1)
* (Insert indication 2)

This letter outlines [Patient Name]’s medical history, prognosis, and treatment rationale.

**Patient’s History**

* Patient’s diagnosis, date of diagnosis
* Laboratory results and date
* Patient’s current medical condition
* Previous and current treatment history
* Patient’s response to previous treatment/therapy

**Rationale for Treatment**

Given the patient’s history, condition, and prescribing information for CIMERLI™, I believe treatment of [Patient Name] with CIMERLI™ is warranted, appropriate, and medically necessary.

The following documentation is enclosed:

* CIMERLI™ full Prescribing Information
* Medical literature regarding the use of CIMERLI™ for (insert disease)
* Relevant clinical documentation such as history and physical, progress notes, treatment history, and outcomes

Please call my office at [Phone Number] if I can provide any additional information. I look forward to receiving your timely response.

Sincerely,

[Physician Name]

[Participating Provider Number]

Enclosures [Attach FDA prescribing information for CIMERLI™ and clinical notes for this patient]

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