*<Name>*

*<Insurance Company/Payer Name>*

*<Address>*

*<City, State, Zip>*

*<Date>*

RE: Member Name: *<Beneficiary First Name/Last Name>*

Member Number: *< Beneficiary Number>*

Group Number: *<Group Number>*

Date of Service: *<XX/XX/XXXX>*

**EXPEDITED REQUEST:** Appeal for payment and coverage of *<insert product name>.*

Dear Medical or Pharmacy Director:

I am writing to request that you approve payment for *<insert product name>* for my patient, listed above, so that they may receive treatment immediately.

My request is supported by the following:

**Summary of Patient History**

*<You may want to include (NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.)>*

* *<Medical Records, including: Patient’s diagnosis, date of diagnosis, and medical history>*
* *<Previous therapies and procedures the patient has undergone for management of patient’s condition>*
* *<Patient’s response to these therapies>*
* *<Summary of your professional opinion of the patient’s likely prognosis without treatment>*

**Rationale for Treatment**

Considering the patient’s history, condition, and the full Prescribing Information supporting use of *<insert product name>*, I believe treatment at this time is appropriate and your coverage determination should be reconsidered.

Given the urgent nature of this request, please provide an expedited authorization. Should you need further information, please contact my office at *<Phone Number>* so we can ensure prompt approval of this course of treatment.

Sincerely, **Enclosures**

Package Insert

*<HCP First/Last Name/Title>* Medical History of Patient

*<Participating Provider Number>* Registration Trial

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