*<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>*

**EXPEDITED REQUEST:** Authorization for treatment with *<insert product name>*

Dear Medical or Pharmacy Director:

I am writing to make an expedited authorization request for my patient to receive treatment with

*<insert product name>*.

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.)>*

* *<Patient’s diagnosis, date of diagnosis, and 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 medical history, condition, and the full Prescribing Information supporting use of *<insert product name>*, I believe treatment at this time is appropriate and medically necessary.

Given the urgent nature of this request, please provide an expedited authorization. Contact my office at *<Phone Number>* so I can provide you with any additional information to ensure prompt approval for this course of treatment.

Sincerely, **Enclosures**

Package Insert

Medical History of Patient

*<HCP First/Last Name/Title>* Registration Trial

*<Participating Provider Number>*

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