**PHYSICIAN LETTERHEAD**

[Date]

[Medical Director]

[Payer Name]

[Address]

[City, State Zip]

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

[Patient Name]

[Patient Date of Birth]

[Subscriber ID Number]

[Subscriber Group Number]

[Case ID Number]

[Dates of Service]

Dear [Medical Director]:

I am writing on behalf of my patient [Patient Name] to [request prior authorization of/document medical necessity for treatment with]CIMERLI, which is indicated for:

* [Wet Age-Related Macular Degeneration (wet AMD)]
* [Diabetic Macular Edema (DME)]
* [Macular Edema Following Retinal Vein Occlusion (RVO)]
* [Diabetic Retinopathy (DR)]
* [Myopic Choroidal Neovascularization (mCNV)]

This letter outlines [Patient Name]’s medical history, diagnosis, 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]

Based on the facts above, I believe CIMERLI is indicated and medically necessary for this patient.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 CIMERLI prescribing information, clinical notes for this patient and relevant peer-reviewed publications.]