SAMPLE Letter of Medical Necessity

<Physician Letterhead>

Date: <Current Date>

Address: <Address of Insurance Company>

Re: <Patient Name>, medical necessity for treating with EKTERLY

Date of birth: <Patient Date of Birth>

Member ID: <Patient ID Number>

Group number: <Patient Group Number>

To <Whom It May Concern>:

I am writing on behalf of my patient, <Patient Name>, to document the medical necessity of EKTERLY® (sebetralstat tablets) for the treatment of hereditary angioedema (HAE). EKTERLY is indicated for the treatment of acute attacks of HAE in patients 12 years of age and older. The treatment of <Patient Name> with EKTERLY is medically necessary and supported by the following information.

Patient medical history and diagnosis:

<Include information on patient's diagnosis, current medical condition, previous and current treatments, and any other relevant information>

Treatment rationale:

I have selected treatment with EKTERLY for my patient based on available clinical data and believe it is the appropriate treatment choice. Given the history and medical needs of <Patient Name>, I believe that acute treatment with EKTERLY is warranted and medically necessary.

If you have any further questions or if any additional information is required, please contact my office at <XXX-XXX-XXXX>. Thank you for your attention to this matter and I look forward to receiving your response.

Sincerely,

<Physician's Name>

<Physician's ID Number>

<Enclosures:>

<Prescribing Information for EKTERLY>

<Patient medical records>

<Other relevant materials and supporting documents>