Instructions:

This template is provided as a resource for healthcare providers when responding to a request from a patient's health insurance company to provide a letter of medical necessity for ZUSDURI™ (mitomycin) for intravesical solution. Please include the required attachments with the letter of medical necessity, including insurance forms, Prescribing Information, and any additional supporting documents. If you need additional references, please contact UroGen Support at 1-833-UROGEN1 (833-876-4361).

When determining if treatment with ZUSDURI is medically appropriate for a patient, please refer to the full Prescribing Information.

Use of this sample letter does not guarantee that the insurance company will provide reimbursement for the medicine requested and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Medical Necessity
(Healthcare Provider Letterhead)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of ZUSDURI
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Group Number]

To whom it may concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of ZUSDURI™ (mitomycin) for intravesical solution, [insert approved indication].

[Patient name] has been diagnosed with low-grade intermediate-risk non-muscle invasive bladder cancer (LG-IR-NMIBC) and has previously received [list all relevant treatments inclusive of therapeutics and/or procedures.]

Patient History and Diagnosis

[Provide a brief description of the patient's medical condition here.]
[Include a short summary of the patient's medical history, including documentation of LG-IR-NMIBC diagnosis, previous treatment regimens, duration of use, and reason for discontinuation.]
[Explain why you believe it is medically necessary for patient to receive ZUSDURI.]
[Describe the potential consequences to the patient if they do not receive ZUSDURI.]
[Obtain and attach supporting letters from any other specialist(s) who is currently providing or has previously provided care to the patient.]
[Include ZUSDURI administration information.]

To conclude, ZUSDURI is medically necessary for the treatment of this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of ZUSDURI.

Sincerely,

[Physician's Name]
[Physician's Practice]
[Physician Contact Information]

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