[Physician Letterhead]

[Insurance Company]

[Address Line 1]

[Address Line 2]

Re: Patient Name: _____

Policy ID: _____

Policy Group: _____

Date of Birth: _____

Re: Appeal of Denied Gene Therapy Coverage [Date]

Reference Number	Lentiviral Vector-based Gene Therapy	Denial Date
[Denied PA or Claim Number]	KRESLADI™ (marnetegragene autotemcel)	[Denial Date]

Dear [Medical/Pharmacy Director]:

I am writing on behalf of my patient, [Patient Name], to request an appeal by a Pediatric Immunology Medical Advisor for your denial of coverage for KRESLADI™ (marnetegragene autotemcel) for the treatment of severe leukocyte adhesion deficiency-I (LAD-I). According to your letter dated [denial date], coverage was denied due to the following reason:

- [Quote denial reason as stated in the denial letter]

The following is a brief description of the patient's medical history:

- Primary diagnosis of severe leukocyte adhesion deficiency-I (LAD-I)
  - [ICD-10-CM code: D71.1: Leukocyte adhesion deficiency]
- [Relevant clinical characteristics and diagnostic testing (eg, CBC, neutrophil count, flow cytometry)]

Based on my clinical judgment and the supporting evidence, as outlined below, I believe that KRESLADI is warranted, appropriate, and medically necessary for [Patient Name]:

[Summarize rationale for treatment, including supporting evidence from:

- Prescribing Information
- Treatment guidelines
- Peer-reviewed literature]

Given the urgent nature of this request, and in view of the above information and the enclosed documentation, please provide timely authorization for KRESLADI.

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Please contact my office at [office phone number] if I can provide you with any additional information to approve this request.

Sincerely,

[Provider Name and Signature]

[Provider Identification Number and Contact Information]

[Treatment Center Name and Address]

Enclosed Documentation:

[Attach and list pertinent documentation, as appropriate]

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