[Insert physician letterhead]

Patient Name: [Member Name]

Date of Birth: [Patient Date of Birth]

Member ID: [Patient ID #]

Date: [Date]

Insurance Plan Name: [Insurance Plan Name]

Insurance Plan Address: [Insurance Plan Address]

Request: Authorization for treatment with KRESLADI™ (marnetegragene autotemcel)

Diagnosis: [Diagnosis and ICD codes]

Dear [Medical Director or Pharmacy Director Name]:

I am writing on behalf of my patient, [Patient Name], to support my request for an authorization to receive treatment with KRESLADI (marnetegragene autotemcel).

[Patient Name] has been under my care for [Amount of time] for the treatment of severe leukocyte adhesion deficiency-I (LAD-I).

Summary of Patient Diagnosis

[Insert patient's diagnosis, date of diagnosis, and relevant lab results]

Summary of Patient History and Treatment Rationale

[Detail the necessary information required to support the medical necessity of treatment.

Utilize your clinical expertise and professional judgment when assessing and describing the patient's condition.]

- Patient's condition, medical history, including all clinical notes and laboratory results
- Disease-specific manifestations and symptoms
- Previous therapies and treatment responses
- Peer-reviewed journals and other medical literature that support use of KRESLADI
- KRESLADI clinical trial data
- Reason for selecting KRESLADI

Based on my clinical assessment of [Patient Name], I believe that KRESLADI is appropriate and medically necessary for the treatment of severe LAD-I.

Given [Patient Name]'s medical and treatment history, please consider coverage for KRESLADI.

If you have any questions or require additional information, please do not hesitate to contact me at [Provider Phone #].

Sincerely,

[Provider Name and Signature]

[Provider Identification Number]

[Provider Address]

[Provider Phone #]

[Provider Fax #]

Enclosed Documentation:

[Attach documentation as appropriate]

- [KRESLADI FDA approval]
- [KRESLADI Prescribing Information]
- [Information stated above]

[Sign off]

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