**IMPORTANT NOTES:**

* **When determining if treatment with VANFLYTA® (quizartinib) is medically appropriate, please refer to the**

**Full Prescribing Information**

* **Visit Daiichi Sankyo Access Central for additional resources, such as a VANFLYTA Prior Authorization Checklist and relevant coding information**
* **Please review the health plan's instructions to determine whether additional enclosures, such as forms, chart notes, test results, or peer-reviewed literature, may also be necessary**
* **Use of the information in this letter does not guarantee coverage for VANFLYTA. It is not intended to be a substitute for, or an influence on, the independent medical judgment of the physician**
* **REMINDER: Translate this sample letter onto your physician's letterhead before printing**

**SAMPLE LETTER OF MEDICAL NECESSITY**

**FOR VANFLYTA® (QUIZARTINIB) TABLETS**

[Date]

[Name]

[Insurance Company]

[Insurance Company Address]

[City, State, ZIP Code]

[Fax Number]

**ATTN: Prior Authorizations/Appeals Department**

Re: Coverage of VANFLYTA® (quizartinib) tablets

[Patient First and Last Name]

[Insurance Policy Number]

[Insurance Group Number]

[Patient Date of Birth]

Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to substantiate the medical necessity of VANFLYTA® (quizartinib) for [Patient Name]. VANFLYTA is FDA approved in combination with standard cytarabine and

anthracycline induction and cytarabine consolidation, and as maintenance monotherapy following consolidation chemotherapy, for the treatment of adult patients with newly diagnosed acute myeloid leukemia (AML) that is FLT3 internal tandem duplication (ITD)-positive as detected by an FDA-approved test.1 VANFLYTA is not indicated as maintenance monotherapy following allogeneic hematopoietic stem cell transplantation (HSCT); improvement in overall survival with VANFLYTA in this setting has not been demonstrated.1 [Patient Name] has been newly diagnosed with AML that is FLT3-ITD+[, and urgently requires treatment initiation]. VANFLYTA is currently the only FDA-approved FLT3 inhibitor to specifically target the ITD+ mutation.

[Patient Name]’s pertinent medical information history is below:

[Insert description, below:

* Diagnosis date and details as well as current medical conditions
* Test results, including but not limited to FLT3-ITD PCR results
* Any previous and/or current AML treatment regimens (including induction or consolidation therapy, if applicable)
* Observed outcomes with any past treatments
* Desired treatment goals
* Patient’s likely prognosis without treatment with VANFLYTA
* Clinical rationale explaining why alternative treatment is suboptimal or inappropriate (eg, efficacy observed in clinical trials, contraindications)]

The information I have provided above justifies that the use of VANFLYTA is medically appropriate and necessary for [Patient Name]. [Enclosed is a copy of (Patient Name)’s medical records]. The full Prescribing Information for VANFLYTA is also enclosed, which serves as further substantiation for the use of VANFLYTA for this patient.

I request that you please approve coverage of VANFLYTA for [Patient Name] as recommended. I appreciate your prompt consideration of this matter. If additional information is needed, I am happy to provide it to you.

Sincerely,

[Physician Name]

[NPI Number]

[Practice Name (if applicable)]

[Address]

[Phone Number]

[Fax Number]

**Reference: 1.** VANFLYTA [package insert]. Basking Ridge, NJ: Daiichi Sankyo, Inc.; 2023.

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