**[Physician Letter Head]**

**Note: This sample letter is provided as a courtesy and is not meant to be directive.**

**[Date]**

**[Payer Contact]**

**[Title/Pharmacy Director]**

**[Payer Company]**

**[Payer Address]**

**[City, State, ZIP]**

RE: Letter of Medical Necessity for VONJO® (pacritinib) capsules

Insured: **[First and Last Name]**

Patient: **[If Different From Insured]**

ID/Policy Number: **[Insured ID/Policy #]**

Group Number: **[Insured Group #]**

Patient Date of Birth: **[Patient Date of Birth]**

Dear **[Name of Payer Contact/Pharmacy Director]**:

I am writing on behalf of my patient, **[Patient Name]**, to document the medical necessity for treatment with VONJO. **[Patient Name]** is an adult who has **[Diagnosis]**. This letter outlines **[Patient Name]**’s medical history and treatment rationale.

**Summary of Patient’s History [Below are some points you may want to include regarding patient’s medical condition]:**

* **Patient’s diagnosis, condition, and medical history, including *ICD-10-CM* codes (per** [**www.cms.gov**](http://www.cms.gov)**), such as:**
  + **D75.81: Myelofibrosis**
  + **D47.4: Osteomyelofibrosis**
  + **D47.1: Chronic Myeloproliferative Disease\***

\*This is a broad diagnosis code, so please also provide an additional myelofibrosis *ICD-10-CM* code and/or ensure that the chart has a documented myelofibrosis diagnosis when appropriate.

* **Relevant test results and lab values, such as:**
  + **Platelet count(s) (within the past 30 days if possible)**
  + **Hemoglobin level(s)**
* **Previous or current treatment plan including**
  + **Medication name and dosage**
  + **Dates and duration of therapy**
  + **Reason for therapy discontinuation**
* **Clinical rationale for prescribing VONJO to include signs that the patient has had a lack of response to prior or current treatments and/or that the disease has progressed, such as:**
  + **No/minimal decrease in spleen volume reduction**
  + **Decrease in platelet count and/or hemoglobin levels**
  + **Increased dependence on transfusions**
  + **Lack of symptom control or increased severity (left rib pain, night sweats, itching, inactivity, abdominal discomfort, early satiety/feeling full, tiredness, fatigue, bone pain)**
* **Summary of your professional opinion of the patient’s likely prognosis or disease progression without VONJO treatment**

**Rationale for Treatment**

Given the patient’s history and condition, I believe treatment with VONJO is warranted, appropriate, and medically necessary.

The attached provides additional information on the VONJO product profile.

I confirm that I have reviewed the VONJO Prescribing Information and am aware of the Indication, the Important Safety Information, and how to prescribe VONJO.

Please call my office at **[Insert Telephone Number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

**[Insert Doctor Name and Participating Provider Number]**

**Resources that you may want to include to justify pacritinib (VONJO) as a therapy option for your patient:**

* + **VONJO** [**Prescribing Information**](https://www.ctibiopharma.com/VONJO_USPI.pdf)
  + **NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®)1 for Myeloproliferative Neoplasmsvia** [**NCCN.org**](https://www.nccn.org/professionals/physician_gls/pdf/mpn.pdf)
  + [**PERSIST-2 data**](https://jamanetwork.com/journals/jamaoncology/fullarticle/2674384)

*ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification*; NCCN=National Comprehensive Cancer Network® (NCCN®).

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