The following is a sample letter of medical necessity for OJJAARA that should be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.*

[Date]
[Payer Contact]
[Title/Pharmacy Director]
[Payer Company]
[Payer Address]
[City, State, ZIP]

RE: Letter of Medical Necessity for OJJAARA (momelotinib)

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 OJJAARA™ (momelotinib). [Patient Name] is an adult who has [Diagnosis]. Below, this letter outlines [Patient Name]'s medical history and treatment needs.
Summary of Patient's History [Below are some points you may want to include regarding patient's medication condition]:

- Patient's diagnosis, condition, and medical history, including relevant test results and ICD-10-CM codes
- Previous therapies that patient has undergone for this diagnosis, including dates and duration of therapy
- Patient response rate to these therapies, including lab values that indicate disease progression or treatment failure
- Brief description of the patient's recent symptoms and condition
- Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment
- Be sure to include documentation that supports why you feel [treatment] is clinically appropriate and could be beneficial [disease management]

Given the patient's history and condition I believe treatment with OJJAARA™ (momelotinib) is warranted, appropriate, and medically necessary.

The attached prescribing information describes the safety and efficacy of OJJAARA™ (momelotinib) in adult patients with [Diagnosis]. Medical records supporting the medical necessity of OJJAARA™ (momelotinib) for this patient is also attached.

Please call my office at [insert telephone number] if I can provide you with any additional information. Give the urgent nature of this request, I thank you in advance for your prompt attention to this matter.

Sincerely,

[Physician Name, Credentials]
[Physician Signature]
[Provider Identification Number]

Enclosures:
Copies of patient medical records
OJJAARA package insert