GUIDE FOR

ZINPLAVA™ (bezlotoxumab) Injection 25 mg/mL

Information for Dosing, Administration, Billing, and Patient Access

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
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Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Introduction

Merck has developed this Product Guide as a tool to help you navigate the health care insurance environment for ZINPLAVA.

The billing and coding information available here is compiled from sources believed to be accurate, but Merck makes no representation that it is accurate. This information is subject to change. Payer coding requirements may vary or change over time, so it is important to regularly check with each payer as to payer-specific requirements. The information available here is not intended to be conclusive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor. Merck and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use given the frequent changes in public and private payer billing. The use of this information does not guarantee payment or that any payment received will cover your costs.

You are solely responsible for determining the appropriate codes and for any action you take in billing. Information about Healthcare Common Procedure Coding System (HCPCS) codes is based on guidance issued by the Centers for Medicare & Medicaid Services (CMS) applicable to Medicare Part B and may not apply to other public or private payers. Consult the relevant manual and/or other guidelines for a description of each code to determine the appropriateness of a particular code and for information on additional codes. Diagnosis codes should be selected only by a health care professional.

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Indication and Usage

ZINPLAVA is indicated to reduce recurrence of Clostridium difficile infection (CDI) in patients 18 years of age or older who are receiving antibacterial drug treatment of CDI and are at a high risk for CDI recurrence.

ZINPLAVA is not indicated for the treatment of CDI. ZINPLAVA is not an antibacterial drug. ZINPLAVA should only be used in conjunction with antibacterial drug treatment of CDI.

Selected Safety Information

In patients with a history of congestive heart failure (CHF), ZINPLAVA should be used when the benefit outweighs the risk. Heart failure was reported more commonly in the two Phase 3 clinical trials in ZINPLAVA-treated patients compared to placebo-treated patients. In patients with a history of CHF, 12.7% (n=15/118) of ZINPLAVA-treated patients and 4.8% (n=5/104) of placebo-treated patients had the serious adverse reaction of heart failure during the 12-week study period. During the same period, for patients with a history of CHF, there were more deaths in ZINPLAVA-treated patients 19.5% (n=23/118) than in placebo-treated patients 12.5% (n=13/104). The causes of death varied and included cardiac failure, infections, and respiratory failure.

Complete safety information can be found on page 11.

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Dosing, Preparation, and Administration

Dosing Recommendations in Adults
The recommended dose of ZINPLAVA is a single dose of 10 mg/kg administered as an intravenous infusion over 60 minutes. The safety and efficacy of repeat administration of ZINPLAVA in patients with CDI have not been studied.

Important Administration Instructions
Administer ZINPLAVA at any time during antibacterial drug treatment for CDI.

Preparation of Diluted Solution
- ZINPLAVA must be diluted prior to intravenous infusion.
- Prepare the diluted solution immediately after removal of the vial(s) from refrigerated storage, or the vial(s) may be stored at room temperature protected from light for up to 24 hours prior to preparation of the diluted solution.
- Inspect vial contents for discoloration and particulate matter prior to dilution. ZINPLAVA is a clear to moderately opalescent, colorless to pale yellow solution. Do not use the vial if the solution is discolored or contains visible particles.
- Do not shake the vial.
- Withdraw the required volume from the vial(s) based on the patient’s weight (in kg) and transfer into an intravenous bag containing either 0.9% Sodium Chloride Injection, USP or 5% Dextrose Injection, USP to prepare a diluted solution with a final concentration ranging from 1 mg/mL to 10 mg/mL. Mix diluted solution by gentle inversion. Do not shake.
- Discard vial(s) and all unused contents.

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Dosing, Preparation, and Administration (continued)

Storage of Diluted Solution

- The product does not contain preservative. The diluted solution of ZINPLAVA may be stored either at room temperature for up to 16 hours or under refrigeration at 2°C to 8°C (36°F to 46°F) for up to 24 hours. If refrigerated, allow the intravenous bag to come to room temperature prior to use.

- These time limits include storage of the infusion solution in the intravenous bag through the duration of infusion.

- Do not freeze the diluted solution.

Administration

- Administer the diluted solution as an intravenous infusion over 60 minutes using a sterile, nonpyrogenic, low-protein binding 0.2 micron to 5 micron in-line or add-on filter.

- The diluted solution can be infused via a central line or peripheral catheter. Do not administer ZINPLAVA as an intravenous push or bolus.

- Do not co-administer other drugs simultaneously through the same infusion line.

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Billing and Coding

The following codes may be relevant for ZINPLAVA and its administration. This information is current as of August 2017. The information provided here is compiled from sources believed to be accurate, but Merck makes no representation that it is accurate. Information about Healthcare Common Procedure Coding System (HCPCS) codes is based on guidance issued by the Centers for Medicare & Medicaid Services (CMS) applicable to Medicare Part B and may not apply to other public or private payers. Note that coverage and billing requirements often differ depending on the setting in which care is provided. Consult the relevant manual and/or other guidelines for a description of each code to determine the appropriateness of a particular code and for information on additional codes. Merck cautions that payer coding requirements vary and can frequently change, so it is important to regularly check with each payer or, where applicable, the Medicare Administrative Contractor, as to payer-specific requirements.

You are solely responsible for determining the appropriate codes and for any action you take in billing. The information provided here is not intended to be definitive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor. Merck and its agents make no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use given the frequent changes in public and private payer billing. The use of this information does not guarantee payment or that any payment received will cover your costs.

Consult the relevant manual and/or other guidelines for a description of each code to determine the appropriateness of a particular code and for information on additional codes. Diagnosis codes should be selected only by a health care professional.

### Possible Relevant Diagnosis Codes

#### ICD-10-CM DIAGNOSIS CODE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A04.7</td>
<td>Enterocolitis due to C. difficile (effective for dates of service on or before September 30, 2017)</td>
</tr>
<tr>
<td>A04.71</td>
<td>Enterocolitis due to C. difficile, recurrent (effective for dates of service on or after October 1, 2017)</td>
</tr>
<tr>
<td>A04.72</td>
<td>Enterocolitis due to C. difficile, not specified as recurrent (effective for dates of service on or after October 1, 2017)</td>
</tr>
</tbody>
</table>


Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Billing and Coding (continued)

NDC and Packaging Information

The NDC is typically required when submitting a claim with a miscellaneous HCPCS code. Please consult with the payer to understand specific billing requirements.

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>PACKAGE</th>
<th>NDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZINPLAVA</td>
<td>Carton containing one 1,000 mg/40 mL (25 mg/mL) single-dose 50 mL vial</td>
<td>0006-3025-00</td>
</tr>
</tbody>
</table>

NDC=National Drug Code.

Please Note: The NDC above is the billable NDC that appears on the carton. The NDC on the vial should not be used for billing purposes.

Below is a list of possible codes that could be relevant for ZINPLAVA and its administration. Please consult with the applicable payer to understand the payer’s specific billing requirements.

HCPCS Codes

Always verify the payer’s coding requirements before submitting a claim.

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>J3590</td>
<td>Unclassified biologics (some payers may prefer the use of “J3490 – unclassified drugs”)</td>
</tr>
<tr>
<td>C9490 (effective July 1, 2017)</td>
<td>Injection, bezlotoxumab, 10 mg (for use only on Medicare hospital outpatient department [HOPD] claims)</td>
</tr>
</tbody>
</table>

*Until a unique J-code is assigned to ZINPLAVA, payers may require a miscellaneous code to be used.

For questions on billing if a portion of the package is wasted, consult the applicable payer’s policy regarding wastage. Please note that starting on January 1, 2017, providers are required to use the JW modifier for Medicare claims with unused drugs or biologicals from single use vials or single use packages that are appropriately discarded.3

Revenue Code for Use in the Hospital Inpatient and Hospital Outpatient Settings

<table>
<thead>
<tr>
<th>REVENUE CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0636</td>
<td>Drugs requiring detailed coding</td>
</tr>
</tbody>
</table>


Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Billing and Coding (continued)

CPT®a Code for Administration

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify the appropriate CPT® code with your payer</td>
<td>Please refer to the AMA CPT 2017 Professional Edition Manual for a complete description of various CPT codes</td>
</tr>
</tbody>
</table>

**Billing Units²**

The HCPCS code for ZINPLAVA for Medicare Hospital outpatient department (HOPD) claims effective July 1, 2017 is C9490 described as: “Injection, bezlotoxumab, 10 mg.” This means that each 10-mg dose equals 1 billing unit, or one-tenth of a vial. It is important to understand that when billing for ZINPLAVA for Medicare HOPD claims using C Code C9490, each 100-mg vial of drug represents 10 units.

**NOTE:** The miscellaneous J-code should still be used for claims prior to July 1, 2017 and for claims that do not fall under Medicare HOPD. Enter a billing unit of 1 when the miscellaneous J-code is used, unless otherwise directed by the applicable payer.

The following chart includes examples of weight-based dosing and illustrates the correlation between vials, milligrams, and billing units.

<table>
<thead>
<tr>
<th>NUMBER OF 1,000-MG VIALS</th>
<th>NUMBER OF MG</th>
<th>NUMBER OF BILLING UNITS BASED ON C9490 (10 MG BEZLOTOXUMAB PER UNIT)²,²b</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>400 mg</td>
<td>40</td>
</tr>
<tr>
<td>1</td>
<td>500 mg</td>
<td>50</td>
</tr>
<tr>
<td>1</td>
<td>600 mg</td>
<td>60</td>
</tr>
<tr>
<td>1</td>
<td>700 mg</td>
<td>70</td>
</tr>
<tr>
<td>1</td>
<td>800 mg</td>
<td>80</td>
</tr>
<tr>
<td>1</td>
<td>900 mg</td>
<td>90</td>
</tr>
<tr>
<td>1</td>
<td>1,000 mg</td>
<td>100</td>
</tr>
<tr>
<td>2</td>
<td>1,100 mg</td>
<td>110</td>
</tr>
<tr>
<td>2</td>
<td>1,200 mg</td>
<td>120</td>
</tr>
</tbody>
</table>

²Only for Medicare HOPD claims; may be updated when a permanent J-code is approved.

For questions on billing if a portion of the package is wasted, consult the applicable payer’s policy regarding wastage. As of January 1, 2017, providers are required to use the JW modifier for Medicare claims with unused drugs or biologicals from single-use vials or single-use packages that are appropriately discarded.


Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
The Merck Access Program

THE MERCK ACCESS PROGRAM CAN HELP ANSWER YOUR QUESTIONS ABOUT

- Insurance coverage for patients
- Prior authorizations and appeals
- Coding and billing
- Potential financial assistance options for eligible patients
- Merck Patient Assistance Program
  - Referral to the Merck Patient Assistance Program for eligibility determination (provided through the Merck Patient Assistance Program, Inc.)

The Merck Access Program is available:

Online at merckaccessprogram-zinplava.com

OR

Call 877-709-4455, Monday through Friday, 8 AM to 8 PM ET

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Selected Safety Information

- In patients with a history of congestive heart failure (CHF), ZINPLAVA should be used when the benefit outweighs the risk. Heart failure was reported more commonly in the two Phase 3 clinical trials in ZINPLAVA-treated patients compared to placebo-treated patients. In patients with a history of CHF, 12.7% (n=15/118) of ZINPLAVA-treated patients and 4.8% (n=5/104) of placebo-treated patients had the serious adverse reaction of heart failure during the 12-week study period. During the same period, for patients with a history of CHF, there were more deaths in ZINPLAVA-treated patients 19.5% (n=23/118) than in placebo-treated patients 12.5% (n=13/104). The causes of death varied and included cardiac failure, infections, and respiratory failure.

- The most common adverse reactions occurring within 4 weeks of infusion with a frequency greater than placebo and reported in ≥ 4% of patients treated with ZINPLAVA and Standard of Care (SoC) antibacterial drug therapy vs placebo and SoC antibacterial drug therapy were nausea (7% vs 5%), pyrexia (5% vs 3%), and headache (4% vs 3%).

- Serious adverse reactions occurring within 12 weeks following infusion were reported in 29% of ZINPLAVA-treated patients and 33% of placebo-treated patients. Heart failure was reported as a serious adverse reaction in 2.3% of the ZINPLAVA-treated patients and 1.0% of placebo-treated patients.

- In ZINPLAVA-treated patients, 10% experienced one or more infusion specific adverse reactions compared to 8% of placebo-treated patients, on the day of or the day after, the infusion. Infusion specific adverse reactions reported in ≥0.5% of patients receiving ZINPLAVA and at a frequency greater than placebo were nausea (3%), fatigue (1%), pyrexia (1%), dizziness (1%), headache (2%), dyspnea (1%), and hypertension (1%). Of these patients, 78% experienced mild adverse reactions, and 20% experienced moderate adverse reactions. These reactions resolved within 24 hours following onset.

- As with all therapeutic proteins, there is a potential for immunogenicity following administration of ZINPLAVA. The detection of antibody formation is highly dependent on the sensitivity and specificity of the assay. Comparison of the incidence of antibodies to bezlotoxumab in the two Phase 3 studies with the incidence of antibodies in other studies or to other products may be misleading. In those 2 Phase 3 studies, none of the 710 evaluable patients tested positive for treatment-emergent anti-bezlotoxumab antibodies.

Before prescribing ZINPLAVA, please read the accompanying Prescribing Information. The Patient Information also is available.
Sample UB-04 (also known as CMS 1450) Claim Form for Hospital Outpatient Department Billing; ZINPLAVA™ (bezlotoxumab) for Injection 25 mg/mL

Note: For questions on billing if a portion of a package is wasted, consult the applicable payer’s policy regarding wastage. Record the amount of drug administered and the amount wasted in the patient’s medical record. Please note that CMS has announced that effective January 1, 2017, Medicare will require the use of the JW modifier on all claims that include wasted product.

Locator 42
- Enter appropriate revenue code for each line item.
- Drugs that are billed with HCPCS codes usually require revenue code 0836—Drugs requiring detailed coding.

Locator 43
- For each line item, enter the description of the revenue code used.
- For the line item for ZINPLAVA (bezlotoxumab), enter both the drug’s brand and generic names.

Locator 44
- Use the appropriate HCPCS code to bill for ZINPLAVA (bezlotoxumab).
- For Medicare hospital outpatient department claims with dates of service on or after July 1, 2017, C9490 (Injection, bezlotoxumab, 10 mg) is available for use.

Locator 46
- Enter the appropriate number of units.
- If using C9490 (which applies to dates of service on or after July 1, 2017), each unit corresponds to 10 mg of ZINPLAVA (bezlotoxumab).
- If using an unspecified HCPCS code (which applies to dates of service before July 1, 2017*), enter only 1 unit in this field.

Locator 47
- Enter appropriate ICD-10-CM diagnosis code(s).

Locator 80
If using an unspecified HCPCS code, enter the following:
- Drug name: [ZINPLAVA (bezlotoxumab)]
- Route of administration
- NDC: 0006-3025-00
- The dosage provided

*Some private payers may prefer the unspecified HCPCS Code for dates of service after July 1, 2017. Check with the relevant payer.

The suggestions contained on this form are compiled from sources believed to be accurate for the Medicare Part B program, but Merck makes no representation that the information is accurate or that it will comply with the requirements of any particular Medicare Administrative Contractor (MAC) or payer. You are solely responsible for determining the billing and coding requirements applicable to any payer or MAC. Diagnosis codes should be selected only by a health care professional. The information provided here is not intended to be conclusive or exhaustive, and is not intended to replace the guidance of a qualified professional advisor or any instructions provided by a payer or MAC. Billing and coding requirements may vary or change over time, so it is important to regularly check these requirements with each payer or MAC. Merck makes no warranties or guarantees, expressed or implied, concerning the accuracy or appropriateness of this information for your particular use and cautions that changes in public and private payer billing requirements occur frequently. The use of this information does not guarantee payment or that any payment received will cover your costs.
Sample CMS-1500 Claim Form for Office Billing: ZINPLAVA™ (bezlotoxumab) for Injection 25 mg/mL

Note: For questions on billing if a portion of a package is wasted, consult the applicable payer’s policy regarding wastage. Record the amount of drug administered and the amount wasted in the patient’s medical record. Please note that CMS has announced that effective January 1, 2017, Medicare will require the use of the JW modifier on all claims that include wasted product.

**Box 19**
- Enter the following:
  - Drug name: ZINPLAVA (bezlotoxumab)
  - Route of administration
  - NDC: 0006-3025-00
  - The dosage provided

**Box 21**
- Enter appropriate ICD-10-CM diagnosis codes

**Box 24 E**
- When using an unspecified HCPCS code, enter only 1 unit in this field

**Box 24 G**
- Use the appropriate unspecified HCPCS code to bill for ZINPLAVA (bezlotoxumab)

*Some Medicare Administrative Contractors may want you to record the total number of vials used. Check with the relevant MAC for details.

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The items and information listed below may be necessary to obtain a prior authorization decision for a medication. It is important to review the insurer’s guidelines for obtaining a prior authorization, as these can differ depending on the insurer, the medication being prescribed, and other factors.

The Items Listed Below May Be Necessary to Obtain a Prior Authorization Decision From an Insurer

- Completed prior authorization request form (if required by patient’s insurer)
  - Note: Some payers may require specific forms to be completed for certain medications or therapeutic areas—always verify that the correct form is completed
- Letter of medical necessity
  - Be sure to note the proposed treatment plan and include the provider ID number in the letter
- Documentation that supports the treatment decision, such as:
  - Prior treatment history and response to treatment
  - Patient history and clinical notes (eg, comorbidities, etc.)
  - Relevant laboratory results
  - Product package insert/physician label
- Additional relevant documentation (if available) regarding the treatment decision

It Might Be Necessary to Provide the Following Information to the Patient’s Insurer When Making a Request for Prior Authorization

- Patient information, including name, insurance policy number, and date of birth
- Physician information, including name and tax ID number
- Facility information, including name and tax ID number
- Date of service
- Patient diagnosis
- Relevant procedure and HCPCS codes for services/products to be performed/provided
- Product National Drug Code (NDC)
- Patient clinical notes detailing the relevant diagnosis and patient medical history

As a provider, you are solely responsible for billing third-party payers correctly, and you should determine if any payer-specific guidelines apply. The information provided here is general in nature and is not intended to be conclusive or exhaustive, nor is it intended to replace the guidance of a qualified professional advisor. Merck and its agents make no guarantees regarding the timeliness or appropriateness of this information for your particular use, given the frequent changes in public and private payer billing.
Appeal Checklist

If a claim for a medication is denied, the items listed below may be helpful in the appeal process. It is important to review the denial and the insurer’s guidelines, as the required documentation and process for making an appeal will be different depending on the insurer and the patient.

As a first step, ensure that the claim was completed and submitted correctly.

**ALWAYS VERIFY THAT**

- The product is covered by the patient’s insurer for the patient’s diagnosis
- A prior authorization or precertification was obtained, if required by the patient’s insurer
- Patient information was recorded correctly (e.g., name, date of birth, insurance policy number, etc.)
- The dosing and duration of therapy are accurate

**PRIOR TO INITIATING THE APPEAL PROCESS, IT IS IMPORTANT TO UNDERSTAND THE FOLLOWING**

- The reason for denial, which may often be found in the explanation of benefits (EOB)
- Instructions for initiating the appeal process
- The necessary forms for appeal completion according to the insurer
- Insurer appeal guidelines regarding what documentation to include
- Filing deadlines and payer review timelines

**BELOW IS A LIST OF FORMS AND DOCUMENTS THAT MIGHT BE HELPFUL WHEN FILING AN APPEAL**

- Letter of medical necessity
  - Be sure to note the proposed treatment plan and include the Provider ID number in the letter
- Formal letter appealing the denial
- Relevant documentation regarding treatment decisions, such as:
  - Prior treatment history and response to treatment
  - Patient history and clinical notes (e.g., comorbidities, etc.)
  - Relevant laboratory results
  - Product package insert/physician label
- Additional relevant documentation (if available) regarding the treatment decision

As a provider, you are solely responsible for billing third-party payers correctly, and you should determine if any payer-specific guidelines apply. The information provided here is general in nature and is not intended to be conclusive or exhaustive, nor is it intended to replace the guidance of a qualified professional advisor. Merck and its agents make no guarantees regarding the timeliness or appropriateness of this information for your particular use, given the frequent changes in public and private payer billing.
ATTENTION: <Medical Director Name and/or Medical Review/Appeals>
<Payer/Health Plan Name>
<Payer Address>

REGARDING: Medical necessity for <Product Name>
PATIENT NAME: <Patient Name>
DATE OF BIRTH: <Patient Date of Birth>
POLICY ID NUMBER: <Policy ID Number>
PROVIDER ID NUMBER: <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>:

I am writing to request authorization for <Product Name> for my patient, <Patient Name>. I have prescribed <Product Name> because this patient has been diagnosed with <diagnosis>, and I believe that therapy with <Product Name> is appropriate for this patient. Attached to this request are clinical notes regarding this patient’s disease state, the FDA approval letter for <Product Name>, and the <Product Name> package insert.

<Product Name> is indicated for <Indication from Prescribing Information>.

<Rationale for treating the patient with <Product Name>. In this rationale, include a description of the patient’s disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

Thank you for taking the time to read this letter. I look forward to your prompt review of this request.

Best regards,

<Physician Signature>
<Physician Name>

ATTACHMENTS TO CONSIDER
• <Product Name> FDA approval letter
• <Product Name> package insert
• Patient clinical notes and other relevant supporting documentation
<Date>

ATTENTION: <Medical Director Name and/or Medical Review/Appeals>
<Payer/Health Plan Name>
<Payer Address>

REGARDING: Denied claim for <Product Name>
PATIENT NAME: <Patient Name>
DATE OF BIRTH: <Patient Date of Birth>
POLICY ID NUMBER: <Policy ID Number>
PROVIDER ID NUMBER: <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>: 

I am writing to appeal the denied claim for <Product Name> for my patient, <Patient Name>, who has been diagnosed with <diagnosis>. Attached to this request are clinical notes regarding this patient’s disease state, the FDA approval letter for <Product Name>, and the <Product Name> package insert.

<Product Name> is indicated for <Indication from Prescribing Information>.

<Rationale for treating the patient with <Product Name>. In this rationale, include a description of the patient’s disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

Thank you for taking the time to read this letter. I believe that treatment with <Product Name> is appropriate for this patient. I look forward to your prompt review of this request.

Best regards,

<Physician Signature>
<Physician Name>

ATTACHMENTS TO CONSIDER
• <Product Name> FDA approval letter
• <Product Name> package insert
• Patient clinical notes and other relevant supporting documentation

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Before prescribing ZINPLAVA™ (bezlotoxumab), please read the accompanying Prescribing Information. The Patient Information also is available.