Dear Health Care Provider,

We have provided this sample Letter of Appeal to assist with appeal of a denial for ORSERDU™ (elacestrant). Use of this document does not guarantee coverage of the medication for your patient.

To use this letter, please feel free to copy or modify the text from the next page at your discretion and paste it onto your practice letterhead. Be sure to replace all bolded and bracketed text with the appropriate patient-specific information before forwarding your customized letter to your patient's insurance provider.

Tips for completing the disease and medical history fields:

- Include specific ICD-10-CM codes where appropriate
- List previous therapy, length of therapy, and outcomes (specify reasons for unsuccessful results)
- Clearly state the rationale for the recommended therapy and why it is appropriate for your patient

Tips for completing the Enclosures field:

- List and enclose documents that support your rationale for the recommended therapy:
  o Summary of patient's medical records
  o Clinical Studies/Journal Articles
  o Copies of medical correspondence
  o Specific information about ORSERDU (elacestrant) such as prescribing information, and treatment guidelines compiled by professional practice organizations)

Be sure to include all the listed enclosures with the appeal letter when you send it to your patient's insurance provider

We hope you find this sample Letter of Appeal to be an important resource to your practice.

Sincerely,

Disclaimer: This is presented for informational purposes only and is not intended to provide reimbursement or legal advice. For your independent consideration and review, please make all changes that you deem appropriate. The treating practitioner in his or her medical judgment is ultimately responsible for the accuracy, truthfulness, and completeness of all claims and communications submitted to third-party payers. Nothing in this document should be construed as a guarantee by Stemline Therapeutics, Inc. regarding coverage or payment by any payor at any specific level, and Stemline Therapeutics, Inc. does not advocate or promote the appropriateness of the use of any billing codes. This template is intended for determining medical necessity and meeting general prior authorization requirements. Please see the ORSERDU™ (elacestrant) FDA-approved label for information relevant to any prescribing decisions.

[Practice Letterhead]

Date: [Insert Date]
[Medical Reviewer/Appeals Reviewer]
[Insurance Company]
[Address]
[City, State, ZIP code]

RE: [Patient Name]
[Patient Date of Birth]
[Patient Insurance Number]
[Group Number]

Reference Number: [Reference Number]
Therapy: ORSERDU (elacestrant)
Submission Date: [Insert Date]
Denial Date: [Insert Date]

Dear [Medical Reviewer/Appeals Reviewer],

I am writing on behalf of my patient, [Patient Name], to request reassessment of your denial of ORSERDU™ (elacestrant) for [indication]. Based on receipt of a letter of denial dated [Date], ORSERDU™ (elacestrant) was denied for [List specific reason stated in the denial letter].

I believe [Patient Name] would benefit from ORSERDU™ (elacestrant) based upon his/her medical history and supporting clinical documentation.

The following clinical documentation are enclosed:

- Clinical Studies/Journal Articles supporting use of ORSERDU™ (elacestrant)
- Applicable coverage policies
- [Copies of medical correspondence]
- [Patient's diagnosis, condition, and treatment history]

Past Treatments	Duration of Therapy	Response to Therapy

[Summarize your professional opinion of the patient's likely prognosis or disease progression without treatment with ORSERDU].

The enclosures support treatment with ORSERDU™ (elacestrant) is medically necessary. Given the urgent nature of this request, please provide a timely response. Please contact my office at [insert phone number] if you require additional information.

Sincerely,

[Physician's name & signature]
[Physician's NPI]