[Office letterhead]

[Date]

[Prior authorization department]

[Name of health insurance company]

[Mailing address]

Re: [Patient Name]

Group/Policy Number: [Number]

Date of birth: [MM/DD/YYYY]

Diagnosis: ICD-10 G40.42 Cyclin-dependent kinase-like 5 deficiency disorder

To Whom It May Concern:

My name is [HCP name] and I am a [board-certified medical specialty] writing on behalf of my patient, [Patient Name], to request coverage for ZTALMY® (ganaxolone). [Patient Name] has been under my care since [insert date] for the treatment of CDKL5 deficiency disorder (CDD).

I understand that the reason for your denial is [include reason provided in the denial letter]. However, based on my patient’s medical history, I have determined that ZTALMY is an appropriate treatment for [Patient Name]. In support of my treatment recommendation, I have provided an overview of my patient’s relevant clinical history below.

[Include brief medical history, including age of seizure onset, genetic testing to confirm diagnosis, seizure types and frequency, prior and current therapies, developmental delays, and impact on quality of life for the patient and family. If patient has previously received ZTALMY, include outcomes and rationale for continuing treatment.

Attach supporting documentation

* Genetic test indicating variant in *CDKL5* gene and date completed
* Other patient labs or diagnostic tests completed (MRI, EEG, CT)
* Relevant clinical/chart notes
* ZTALMY FDA approval letter
* ZTALMY Prescribing Information
* Relevant publications]

ZTALMY is indicated specifically for seizures associated with CDD in people 2 years of age and older.

[Include rationale for prescribing ZTALMY. Provide details about your patient’s likely clinical course and prognosis without this treatment]

[List scientific publications used for support, etc] are enclosed, which offer additional support for ZTALMY.

Please reconsider coverage of ZTALMY for my patient and contact me at [telephone number] or [email] if you require additional information.

I look forward to your approval of this claim.

Sincerely,

[Physician’s name and signature]

[Physician’s medical specialty]

[Physician’s NPI]

[Physician’s office/practice name]

[Phone #]

[Email]

[Fax #]

Enclosures [attach as appropriate]

[FDA approval letter]

[Prescribing Information]

[Clinical notes and laboratory results]

[Publications]