

[Date]  
[Health plan name]

ATTN: [Contact title/medical director]  
[Contact name (if available)]  
[Health plan address]  
[City, State, ZIP]

Re: Letter of Medical Necessity for KAPSPARGO SPRINKLE™ (metoprolol succinate) extended-release capsules

[Patient name]  
[Date of birth]  
[Insurance ID number]  
[Insurance group number]  
[Case ID number]  
[Date of service]

Dear [Contact name/Medical director],

This letter is sent on behalf of [patient's name] to document that [he/she] has clinical rationale for Kaspargo Sprinkle™. I am writing to document my patient's medical history and diagnosis and summarize my treatment rationale. Treatment with Kaspargo Sprinkle™ [dose, frequency] is medically appropriate and necessary for this patient.

[Patient's name] is a [age]-year-old [gender] who was diagnosed with [x] on [date]. [Patient's name] has been in my care since [date]

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

Considering my patient's history, condition, and the full Prescribing Information supporting the use of Kaspargo Sprinkle™ I believe treatment with Kaspargo Sprinkle™ is appropriate, medically necessary, and should be covered and reimbursed. Enclosed you will find other relevant supporting documentation.

Please contact my office by calling [phone number] for any additional information you may require. I look forward to your timely approval.

Sincerely,  
[Physician's signature]  
[Physician's name]

Suggested enclosures:  
Package insert for Kaspargo Sprinkle™  
Copy of patient medical records  
Other supporting documentation

PM-US-KAP-0061