[Medical Director Name] Re: [Member Name]
[Name of Payer]
[Insert Member Number]
[Insert Group Number]
[Payer Address]

Dear **[Insurance Company Contact]**:

I am writing to request a reconsideration of my request for the treatment of **[insert patient name]** with **{select Titan® inflatable penile prosthesis or Genesis® malleable penile prosthesis}** In brief, the surgery with **{select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis }** is medically appropriate and necessary and should be a covered treatment by your plan. This letter outlines **[patient name]**'s medical history, prognosis, and treatment rationale.

{Include appropriate indication for your selected product} The Titan and Titan Touch® Inflatable Penile Prosthesis is indicated for male patients suffering from erectile dysfunction (impotence) who are considered to be candidates for implantation of a penile prosthesis.

The Genesis Malleable Penile Prosthesis (Prosthesis) is designed for the management of erectile dysfunction (impotence) stemming from a variety of causes, including: epispadias, pelvic fracture, spinal cord injury or disease, prostatectomy, cystectomy, abdominal-perineal resection, multiple sclerosis, diabetes mellitus, alcoholism, arteriosclerosis and hypertensive vascular disease, priapism, and Peyronie's disease. The Prosthesis may also be used in selected patients with psychogenic impotence.

[Payer/Plan name] has denied coverage of **{select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis}** for **[patient's name]** because **[insert reason for denial as indicated on the authorization denial]**. The following rationale supports my decision to prescribe **{select Titan inflatable penile prosthesis or Genesis malleable prosthesis}**:

In my judgment, **[treatment plan that is suggested]** is not a medically appropriate treatment for **[insert patient name]** because he has **[insert rationale, e.g., personal medical history/family history, contraindication, comorbid condition(s), prior inadequate response, or adverse reaction to treatment plan is suggesting]**.

- **Summary of Patient's History and Diagnosis [Insert summary of patient history and diagnosis per your medical judgment].**
- **Document that patient previously tried treatment for {diagnosis}**
- **Description of patient's recent symptoms/condition and how it is affecting lifestyle (can include depression, loss of work, relationships etc.)**
- **Lab test results and applicable dates**

Please contact my office if you need any other information to review my case **[enter PHONE]**. I look forward to resolving this denial in a timely manner so that I can schedule the surgery for my patient.

Sincerely,

[Name, credentials]

Attachments:

This form letter has been provided by Coloplast for review by the physician treating the patient who will be referenced in this letter. The physician should review relevant information about the patient and make an independent medical determination regarding medical necessity. This form letter should only be completed by a physician who has concluded that the treatment is medically necessary for this patient as described. This letter is intended to be reviewed and completed by a physician. It is not medical advice or a replacement for the independent medical judgment of a trained and licensed physician.

Coloplast Corp. Minneapolis, MN 55411 / Interventional Urology Surgical Support 1-800-258-3476