[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 an exception to the policy {Name of policy, Policy number reference} for the treatment of **[insert patient name]**'s erectile dysfunction (ED) 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. 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. This letter outlines [patient name]'s medical history, prognosis, and treatment rationale.

[Payer/Plan name] policy does not currently cover the use of **{select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis}** for **[patient's name]**'s diagnosis of ED because it may be a member or plan exclusion with their employer. We ask that you review the following medical documentation and make an exception of coverage to this policy for patient **{insert name}** The following rationale supports my decision to utilize **{select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis}** for his ED:

In my judgment, **[select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis}** is 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 with 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