Please review the important information on page 2

[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 authorization for the treatment/surgery of **[insert patient name]** with the Torosa® Saline-Filled Testicular Prosthesis. In brief, this surgery is medically appropriate and necessary and should be a covered by your plan. This letter outlines **[patient name]**'s medical history, prognosis, and treatment rationale.

The TOROSA Saline-Filled Testicular Prosthesis is intended for use when cosmetic testicular replacement is indicated i.e., in the case of agenesis or following the surgical removal of a testicle. A testicular implant may help alleviate feelings of loss, uneasiness, and shame resulting from orchiectomy.

[Payer/Plan name] {does/does not} have a policy **{enter policy name, reference number}** pertaining to the coverage of cosmetic prostheses or more specifically, Torosa**.** My patient **[patient's name]** does meet the criteria detailed within **{policy XXX}** as listed below. The following rationale supports my decision to treat my patient with the Torosa Saline-Filled Testicular Prosthesis:

In my judgment, a Torosa Saline-Filled Testicular Prosthesis is a medically appropriate treatment for **[insert patient name]** because he has **[insert rationale, e.g., personal medical history, reason for absent testicle].**

- **Summary of Patient's History and Diagnosis [Insert summary of patient history and diagnosis per your medical judgment]**
- **Document length that patient has needed this prosthesis {diagnosis}**
- **Description of patient's recent symptoms/condition and how it is affecting lifestyle (can include depression, loss of work, relationships etc.)**

Torosa, like any cosmetic implant, is designed to help restore a more natural look and feel of the testicles in the scrotum and may increase confidence in patients who have lost a testis to disease. 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. Coloplast provides this information for the treating clinician's convenience only. This letter is not offered as a recommendation regarding clinical practice. 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. Please consult Medicare billing specialists, other payers, reimbursement specialists and/or legal counsel for interpretation of coverage and payment policies.

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