

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 coverage for the treatment/surgery 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.

[Select product/indication that applies]The Titan and Titan Touch Inflatable Penile Prosthesis are indicated for male patients suffering from erectile dysfunction (impotence) who are considered to be candidates for implantation of a penile prosthesis OR Genesis malleable penile prosthesis is designed for the management of 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] does have a policy **[enter policy name, reference number]** pertaining to the coverage of sexual dysfunction or more specifically, penile prostheses. My patient, **[patient's name]** does meet the criteria detailed in the above-named policy as listed below. The following rationale supports my decision to treat my patient with the **[select Titan inflatable penile prosthesis or Genesis malleable penile prosthesis]**:

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, based on information that the patient has provided to you e.g., personal medical history/family history, contraindication, comorbid condition(s), prior inadequate response, or adverse reaction to a payer suggested treatment plan]**.

- **Summary of patient's history and diagnosis (duration of treatment for this condition)**
 - **Document previously tried/failed treatment(s)**
- **Lab work and other test results including dates performed (e.g. Doppler)**
- **Description of patient's recent symptoms/condition and how it is affecting lifestyle (e.g. this may include based on information that the patient has provided to you, depression, loss of work, relationships etc.)**

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 surgery for my patient.

Sincerely,

[Name, credentials]

Attachments:

This form letter is provided by Coloplast for review by the physician treating the patient referenced in this document. It is offered solely for the clinician's convenience. Coloplast provides accurate and objective information intended to support the appropriate and efficient use of Coloplast products; however, this letter is not a recommendation regarding clinical practice. This letter is intended for review and completion by a physician. It does not constitute medical advice and does not replace the independent medical judgment of a trained and licensed clinician. For guidance on coverage and payment policies, please consult Medicare billing specialists, other third-party payers, reimbursement experts, or legal counsel.