[Insert Name of Medical Director] RE: Member Name: [Insert Member Name]

[Insert Insurance company Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State Zip]

**REQUEST:** Authorization for treatment with [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] (glucagon injection)

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE:** [Insert Dose]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to request a **formulary exception** for the above-mentioned patient to receive treatment with [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] for [insert diagnosis, for example, severe hypoglycemia]. In brief, [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] is not on [insert plan name]’s formulary, but [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] is a medically appropriate and necessary treatment for this patient. Based on the following documentation, I am requesting [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] to be considered for this patient.

**Note: Exercise your independent medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.**

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient’s History**

[Insert:

* Previous therapies/procedures and response to those interventions
* Description of patient’s recent symptoms/condition

**Rationale for Treatment**

[Insert summary statement for rationale for treatment such as: Considering the patient’s history, condition, and the full Prescribing Information supporting uses of <Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe>, I believe treatment with <Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe> at this time is medically necessary and should be a covered and reimbursed service.

You may consider including documents that provide additional clinical information to support the recommendation for <Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe> for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request], please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosures [Include full Prescribing Information and the additional support noted above]

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