

## **SAMPLE Letter of Medical Necessity**

This sample letter and related information are provided for informational purposes only. It provides an example of the types of information that may be provided when responding to a request from a patient's health plan/insurer to provide a Letter of Medical Necessity. Health plan requirements may vary, so the prescriber should refer to the prior authorization or coverage information specific to their patient's health plan before completing a Letter of Medical Necessity. Use of the information in this letter does not guarantee coverage or that the health plan will provide reimbursement, and is not intended to be a substitute for or to influence the independent medical judgment of the physician. It is the responsibility of the prescriber and/or their office staff, as appropriate, to determine the correct diagnosis, treatment protocol, and content of all such letters and related forms for each individual patient. The prescriber should refer to the Important Safety Information in the full Prescribing Information when determining whether the product is medically appropriate for a patient.

[Contact name]

[Health plan name]

[Health plan address]

[City, State ZIP Code]

[Fax number]

Re: Letter of Medical Necessity for [Product] [Strength]

Patient: [Patient Name]

Group/policy number: [Number]

Date(s) of service: [Dates]

Diagnosis: [Code & Description]

Dear [Insert contact name or department]:

My name is [Provider First Name Provider Last Name, medical specialty (National Provider Identifier number)], and I am writing on behalf of my patient, [Patient Name], to [request prior authorization/document medical necessity] for treatment with [DrugName]. [Drug Name] is indicated for treatment of [indication]. This letter serves to document that [Patient Name] has a diagnosis of [diagnosis] [ICD-10 Code] and requires treatment with [Drug Name], and that it is medically necessary for [him/her] as prescribed. On behalf of [Patient Name], I am requesting approval for use and subsequent payment for the treatment with [Drug Name].

### **Summary of Patient Medical History and Diagnosis**

[Patient Name] is a [AGE]-year-old [male/female] diagnosed with [diagnosis]. [Patient Name] has been in my care since [date].

### Clinical Rationale for [Product]

Given [Patient Name]'s medical history—including [diagnosis, current medications, allergies, comorbidities, and ICD code(s)]—and the supporting clinical documentation (see attached [medical records, lab reports, etc.]), and therefore, a [transdermal treatment] with [Product] is appropriate and medically necessary. [Product] is indicated for [drug indication], and in this case, is preferred because [explain why this option is best suited to the patient's unique profile]. Relevant clinical guidelines and literature[, such as (refer to specific guideline or piece of literature),] support the use of [Product] in patients with [medical condition]. The planned treatment course is [insert dosing and treatment course].

In summary, [Drug Name] is medically necessary and reasonable for [Patient Name]'s medical condition and warrants coverage. Please contact me at [physician telephone number] if you require additional information about this case. Thank you for your prompt attention.

Sincerely,

[Physician Name], <DEGREE>

[Provider ID number]

Enclosures: [Attach as appropriate]:

[Prescribing Information]

[Clinic notes]

[Relevant patient medical records and/or labs]

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