SAMPLE LETTER OF MEDICAL NECESSITY

Payers may require prior authorization or supporting documentation in order to process and cover a claim for the requested therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific letter of medical necessity will help to explain the physician's rationale and clinical decision making in choosing a therapy. The following is a sample letter of medical necessity that can be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.*

[Date]

[Contact Name of medical director or other payer representative]
[Contact Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP]
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]:

I am writing on behalf of my patient, [PATIENT NAME], to [REQUEST PRIOR AUTHORZATION/DOCUMENT MEDICAL NECESSITY] for treatment with [Product]. [Product] is indicated for treatment of [Indication Statement].This letter serves to document that [PATIENT NAME] has a diagnosis of [DIAGNOSIS] and needs treatment with [Product], and that [Product] is medically necessary for [him/her] as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatment.

Patient Medical History and Diagnosis

[PATIENT NAME] is a [AGE]-year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with [Product].

Based on the above facts, I am confident that you will agree that [Product] is indicated and medically necessary for this patient. The plan of treatment is to start the patient on [Product], [monitor platelet count, response to therapy, dose adjustments and requirements].

Please consider coverage of [Product] on [PATIENT NAME]'s behalf and approve use and subsequent payment for [Product] as planned. Please refer to the enclosed Prescribing Information for [Product]. If you have any further questions regarding this matter, please do not hesitate to call me at [PHYSICIAN TELEPHONE NUMBER]. Thank you for your prompt attention to this matter.

Sincerely,
[PHYSICIAN NAME], <DEGREE INITIALS>
[PROVIDER IDENTIFICATION NUMBER]

Enclosures: (Attach as appropriate)
- FDA approval letter
- Prescribing Information (PI)
- Clinic notes & labs

CC: [Medical Director, patient, specialty society, Insurance Commissioner]

***NOTE: This sample letter and related information are provided for informational purposes only. It is the responsibility of the HCP 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 and submit. Salix Pharmaceuticals does not guarantee coverage or reimbursement for the product.**

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