SAMPLE Letter of Medical Necessity

This sample letter and related information is 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 AUTHORZATION/DOCUMENT MEDICAL NECESSITY] for treatment with [Drug Name]. [Drug Name] is indicated for treatment of [Indication Statement]. This letter serves to document that [PATIENT NAME] has a diagnosis of [DIAGNOSIS] [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]. [NAME OF PATIENT] has been in my care since [DATE].

Clinical Rationale for [Product]
Given the [PATIENT NAME]'s history, condition, and the supporting clinical information [attached supporting medical records, laboratory reports, etc.], I believe [transdermal treatment for] [PATIENT NAME] with [Product] is warranted, appropriate and medically necessary. [Drug Name] is indicated for [Drug Indication]. The accompanying prescribing information provides the approved clinical information for [Drug Name]. The plan of treatment is to start the patient on [Drug Name], [provide 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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