

This sample letter is for demonstration purposes only. Use of this template or the information in this template does not guarantee reimbursement for coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.

<Date>

**ATTENTION:** <Medical Director Name and/or Medical Review/Appeals>

<Payer/Health Plan Name>

<Payer Address>

**REGARDING:** Medical necessity for <Product Name>

**PATIENT NAME:** <Patient Name>

**DATE OF BIRTH:** <Patient Date of Birth>

**POLICY ID NUMBER:** <Policy ID Number>

**PROVIDER ID NUMBER:** <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>:

I am writing to request authorization for <Product Name> for my patient, <Patient Name>. I have prescribed <Product Name> because this patient has been diagnosed with <diagnosis>, and I believe that therapy with <Product Name> is appropriate for this patient. Attached to this request are clinical notes regarding this patient's disease state, the FDA approval letter for <Product Name>, and the <Product Name> package insert.

<Product Name> is indicated for <indication from prescribing information>.

<Rationale for treating the patient with <Product Name>. In this rationale, include a description of the patient's disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

Thank you for taking the time to read this letter. I look forward to your prompt review of this request.

Best regards,

<Physician Signature>

<Physician Name>

#### **ATTACHMENTS TO CONSIDER**

- <Product Name> FDA approval letter
- <Product Name> package insert/prescribing information
- Patient clinical notes and other relevant supporting documentation