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
- Patient clinical notes and other relevant supporting documentation