**Letter of Medical Necessity Template**

[Physician practice letterhead]

[Contact name] Re: [Insured patient name]

[Insurance company] [Patient date of birth]

[Insurance company street address] Policy number: [policy number]

[Insurance company city, state, ZIP] Group number: [group number]

[Date]

Subject: Intent to treat with [drug name]

Dear [contact name],

I am writing on behalf of my patient, [patient name], to request approval to treat [him/her]

with [drug name] for [diagnosis]. [Drug name] is an FDA-approved [description of product]

and will be procured [means of ordering]. In clinical trials, patients taking [drug name] showed [describe clinical trial results]. This letter provides clinical history and rationale to support the use of [drug name] for the treatment of [diagnosis].

[Patient name] is a [age]-year-old [male/female] diagnosed with [diagnosis and ICD-10

code] by [physician] and has been in my care since [year]. My current treatment plan

includes [current therapies and dosages]. [Patient name] has previously tried [prior

therapies and reasons for discontinuation].

I believe treatment with [drug name] is medically necessary for [patient name] because:

1. [Reason for prescribing treatment]
2. [Reason for prescribing treatment]
3. [Reason for prescribing treatment]

Please promptly review the information that I have provided in order to authorize treatment with [drug name] and verify [patient name]’s coverage for [drug name]. I can be reached at

[physician phone number] or [physician email address] if additional information is required

for approval of this request.

Thank you for your immediate attention to this very important matter.

Sincerely,

[Physician name]

[Practice name]

[Practice address]

**Enclosures** (suggested):

[Drug name] FDA approval letter

[Drug name] Prescribing Information

Relevant medical records