# 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 _____ _____

Patient: _____
Group/policy Number: _____
Date(s) of service: _____
Diagnosis: _____

Dear _____

I am writing on behalf of my patient, _____, to _____ for treatment with _____. _____ is indicated for treatment of _____.This letter serves to document that _____ has a diagnosis of _____ and needs treatment with _____, and that _____ is medically necessary for _____ as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatment.

**Patient Medical History and Diagnosis**

_____ is a _____-year-old _____ diagnosed with _____. _____ has been in my care since _____. As a result of _____, my patient _____. Additionally, _____ has tried _____ and _____. The attached medical records document _____'s clinical condition and medical necessity for treatment with _____.

Based on the above facts, I am confident that you will agree that _____ is indicated and medically necessary for this patient. The plan of treatment is to start the patient on _____, _____.

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

Sincerely,

_____, _____

_____

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

CC: _____



***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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