IMPORTANT NOTES:

- **Visit AR Assist® for additional resources, such as prior authorization checklist, enrollment form.**
- **Please review the health plan's instructions to determine whether additional enclosures, such as forms, chart notes, test results, or peer-reviewed literature, may also be necessary**
- **Use of the information in this letter does not guarantee coverage. It is not intended to be a substitute for, or an influence on, the independent medical judgment of the physician**
- **REMINDER: Letters of medical necessity should appear on the submitting physician's letterhead**

SAMPLE LETTER OF MEDICAL NECESSITY

[Date]

[Name]
[Insurance Company]
[Insurance Company Address]
[City, State, ZIP Code]
[Fax Number]

ATTN: Prior Authorizations/Appeals Department

Re: Coverage of [PRODUCT Name]
[Patient First and Last Name]
[Insurance Policy Number]
[Insurance Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to substantiate the medical necessity of [PRODUCT Name] for [Patient Name]. [Insert information on PRODUCT Name, supporting use of PRODUCT. Treatment with [PRODUCT Name] is medically necessary based on [Patient Name]'s confirmed diagnosis of [Disease State], This letter outlines [Patient's name]'s medical history, prognoisis and treatment rationale.

[Patient Name]'s pertinent medical information history is below:
[Insert description, below:

- Diagnosis date and details as well as current medical conditions
- Test results
- Any previous and/or current treatment regimens
- Observed outcomes with any past treatments
- Desired treatment goals
- Patient's likely prognosis without treatment with [PRODUCT Name]
- Clinical rationale explaining why alternative treatment is suboptimal or inappropriate (eg, efficacy observed in clinical trials, contraindications)]

The information I have provided above justifies that the use of [PRODUCT Name] is medically appropriate and necessary for [Patient Name]. [Enclosed is a copy of (Patient Name)'s medical records].

I request that you please approve coverage of [PRODUCT Name] for [Patient Name] as recommended. I appreciate your prompt consideration of this matter. If additional information is needed, I am happy to provide it to you.

Sincerely,
[Physician Name]
[NPI Number]
[Practice Name (if applicable)]
[Address]
[Phone Number]
[Fax Number]