<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> because this patient has been diagnosed with <Diagnosis>, and I believe that this patient would benefit significantly from therapy with <Product Name>. Attached to this request is the FDA approval letter for <Product Name> and clinical notes regarding this patient’s disease state.

<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.
I believe that treatment with <Product Name> is appropriate for this patient.

Best regards,

<Physician Signature>
<Physician Name>

ATTACHMENTS TO CONSIDER:

- <Product Name> FDA approval letter and package insert/physician label
- Patient clinical notes and any other relevant supporting documentation