

SAMPLE LETTER OF MEDICAL NECESSITY

[Name]
[Insurance Company/Payer Name]
[Address]
[City, State, Zip]
[Date]

RE: Member Name: [Member Name]
Member Number: [Member Number]
Group Number: [Group Number]

EXPEDITED REQUEST: Authorization for treatment with [Medication]

Dear Medical or Pharmacy Director:

I am writing to make an expedited authorization request for my patient to receive treatment with [Medication].

My request is supported by the following:

Summary of Patient History

[You may consider including (NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.)

- Patient's diagnosis, date of diagnosis, and history
- Previous therapies and procedures the patient has undergone for management of patient's condition
- Patient's response to these therapies
- Summary of your professional opinion of the patient's likely prognosis without treatment]

Rationale for Treatment

Considering the patient's history, condition, and the full Prescribing Information supporting use of [Medication], I believe treatment at this time is [provide clinical justification for treatment].

Given the urgent nature of this request, please provide an expedited authorization. Contact my office at [Phone Number] if I can provide you with any additional information to ensure prompt approval of this course of treatment.

Sincerely,

[Doctor Name]

[Participating Provider Number]

Enclosures

The information contained in this sample letter is provided by Takeda for informational purposes only for patients who have been prescribed a Takeda medicine. There is no requirement that any patient or healthcare provider use a Takeda product in exchange for this information. This sample letter is not meant as a substitute for a prescriber's independent medical decision-making.