Sample Letter of Medical Necessity

Patient to remain on current drug therapy

[Date]

[Physician Name]
[Health Care Practice Name]
[Health Care Practice Address]
[City, State, Zip Code]

[Insurance Name and DOB]
[Patient Name]
[Patient Insurance ID#]
[Reference Number if Available]

Dear Medical or Pharmacy Director:

This letter of medical necessity is in regards to your coverage policy that does not provide coverage for [Drug name] for the treatment of [Diagnosis]. I have reviewed your drug coverage policy and feel that [Patient name and ID#] should be covered for [Drug name] as it is medically necessary to treat their diagnosis of [Diagnosis and ICD-10 code]. I am requesting for the patient to be approved to continue on [Drug name].

I have been treating my patient since [Date] to manage their disease. My patient has been on [Drug name] since [Date]. [The patient has had the following experience on the drug:]

In my medical opinion, I believe that abandoning an effective drug therapy that is successfully treating my patient's disease is not the right choice based on my medical decision-making judgement for the following reason(s): [Insert reason(s)].

Included with this letter of medical necessity for the patient to be approved to continue their treatment of [Drug name] are relevant medical history notes, supporting clinical trials information and FDA approval data.

[Summarize the reason for the patient to remain on [Drug name]. Please feel free to contact me if I can provide further information or a peer to peer review for your approval of medical necessity for [Drug name].

Sincerely,

[Physician name]
[Phone number]
[Fax number]