Sample Letter of Medical Necessity

Patient to convert to a new drug therapy

[Date]

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

[Insured Name and DOB]
[Patient Name]
[Patient Insurance ID#]
[Request Reference Number]

Dear Medical or Pharmacy Director:

This letter of medical necessity is in regards to your coverage policy for [Drug name]. 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 the patient's diagnosis of [Diagnosis and ICD-10 code]. The appropriate treatment for the patient at this time is to discontinue [Drug name] and to prescribe [Drug name] to treat my patient.

I have been treating my patient since [Date] to manage [his/her] disease. The patient has been on [his/her] currently utilized drug [Drug name] since [Date].

My rationale for prescribing [Drug name] include:

- [Reason(s) supporting changing to new drug prescription]

Included with this letter of medical necessity for the patient to change to [Drug name] are relevant supporting medical documentation, clinical trial information and FDA approval for the patient's diagnosis.

[Summarize reasons for the patient to convert to utilizing the recommended new drug]. 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]