Jazz Cares®

Making a difference in Patients' lives, one Patient at a time

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Please see below a sample letter of medical necessity for example purposes only. This sample letter provides insight into what plans may consider relevant information regarding your patient's treatment. Please note that submitting the information below to the health plan does not guarantee they will provide coverage for the prescribed medication, and some plans may require different or additional information. This example is not meant as a substitute for a prescriber's independent medical decision-making.

{Date Created}

{Provider_Full_Name}
{Site_Address1} {Site_Address2}
{Site_City}, {Site_State} {Site_Zip}

{Contact Name} (Usually the medical director)
{Title}
{Name of the Health Insurance}
{Address Street}
{Address. City, State and Zip Code}

RE:
Insured: *{Patient Name}*
Date of Birth*: {DOB}*
Policy Number: *{Number}*
Group Number: *{Number}*
Case ID: *{Number}*

Dear Dr. *{Medical Director's Name}*,

I am writing to you on behalf of my patient *{Patient Name}* to request reimbursement for *{Product Name}*. *{Patient's First Name's}* plan does not cover *{Product Name}* at this time, however, it is my professional opinion as a specialist that it is medically necessary for him/her. *{Patient's First Name}* has been under my care since *{date}* for the treatment of *{Diagnosis}*.

Please see the attached documentation, regarding *{product name and/or patient's first name}* to assist with your coverage decision.

- Include rationale why this is medically necessary at the dosage prescribed
- List all *{patient's name}* previously tried and failed therapies (either for efficacy or tolerability)

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- Include any pertinent diagnostic tests, such as EEG, MRI or genetic testing
- Provide reasons to substantiate why this would be the next logical step for treatment in your medical judgement
- Include any pertinent medical records that support your decision to prescribe *{Product Name}*
- Include published data that you feel supports *{Product Name}* use for the patient's condition
- Any other considerations for inclusion

Based upon the clinical rationale I have included, I request your approval of *{Product Name}* as appropriate and medically necessary for my patient. If any further information is necessary for approval of this request,please feel free to call me at *{Prescriber's phone number}* to discuss.

Thank you in advance for your immediate attention to this request so that I may move forward with treating this patient as I deem necessary for their health.

Sincerely,

{Prescriber's Signature}

{Prescriber's Name}