Date: [Date]

To: [Insurance Company Name/Medical Review Board]
Attention: [Department Name]
Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Puberty Suppression Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request coverage for puberty suppression therapy (GnRH analogues) for my patient, [Patient Name]. I have been treating [Patient Name] since [Date] for a diagnosis of Gender Dysphoria (ICD-10 Code: F64.0/F64.2).

Based on the World Professional Association for Transgender Health (WPATH) Standards of Care and the Endocrine Society Clinical Practice Guidelines, puberty suppression is a medically necessary intervention for this patient. [Patient Name] has reached Tanner Stage [Stage Number] and is experiencing significant clinical distress due to the development of secondary sex characteristics that are incongruent with their gender identity.

Clinical Justification:
The goal of this treatment is to pause the physical changes of puberty, thereby alleviating the psychological distress associated with gender dysphoria and preventing the development of permanent physical features that would require invasive surgeries in the future. [Patient Name] meets all clinical criteria for this treatment, including:

- A long-standing and persistent pattern of gender non-conformity.
- Gender dysphoria that emerged or intensified at the onset of puberty.
- The cognitive and emotional capacity to provide informed consent (with parental/guardian support).
- Absence of co-morbidities that would interfere with treatment.

The prescribed medication is [Medication Name, e.g., Lupron Depot/Supprelin LA]. This treatment is reversible and is the standard of care for adolescents in this clinical situation. Delaying or denying this treatment poses a significant risk to the patient's mental health, including increased risks of depression, anxiety, and self-harm.

I request that you approve coverage for this medically necessary treatment immediately. If you require further documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Board Certification/Specialty]
[Clinic/Hospital Name]
[NPI Number]