[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

[Insurance Company Name]
[Prior Authorization/Appeals Department]
[Address]
[City, State, Zip Code]

RE: Letter of Medical Rationale for Off-Label Use

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to formally request coverage for **[Name of Medication]** for my patient, **[Patient Name]**. While this medication is not FDA-approved specifically for **[Diagnosis/Condition]**, its use is medically necessary and supported by clinical evidence for this patient's specific presentation.

Clinical History and Diagnosis:
The patient was diagnosed with [Condition] on [Date]. Current symptoms include [List Symptoms]. The patient's condition is [Stable/Progressive/Severe], requiring immediate pharmacological intervention to prevent [Complications/Hospitalization].

Previous Therapies Attempted:
The patient has previously tried and failed the following FDA-approved or formulary-preferred treatments:

- [Drug A]: [Duration] - Result: [Ineffective/Side Effects]
- [Drug B]: [Duration] - Result: [Ineffective/Side Effects]

Rationale for Off-Label Use:
I am prescribing [Medication] off-label based on the following medical rationale:
[Insert explanation of why this drug is appropriate, e.g., similar mechanism of action to approved drugs, specific genetic markers, or failure of all standard options].

Supporting Clinical Evidence:
The use of [Medication] for [Condition] is supported by:

- [Citation of Peer-Reviewed Journal Article/Study]
- [Citation of Clinical Practice Guidelines]
- [Compendia Support, e.g., AHFS DI, Micromedex]

Based on the patient's clinical history and the attached supporting documentation, I request that you grant an exception and cover [Medication] as a medically necessary treatment.

Please contact my office at [Phone Number] if you require additional information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]

Enclosures:
[Clinical Notes]
[Peer-Reviewed Literature Copies]
[Test Results/Lab Reports]