Date: [Insert Date]

To: [Insurance Company Name]
Attention: Medical Review/Prior Authorization Department
Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Pharmacogenomic (PGx) Testing

Patient Name: [Patient Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]

To Whom It May Concern,

I am writing to request coverage for pharmacogenomic (PGx) genetic testing for the above-referenced patient. As the patient's treating physician, I have determined that this testing is medically necessary to guide pharmacological treatment and avoid Adverse Drug Reactions (ADRs).

Patient Clinical History:
The patient has been diagnosed with [Insert Diagnosis/ICD-10 Codes]. Currently, the patient is [experiencing significant side effects from / failing to respond to] the following medications: [List Current/Past Medications].

Rationale for Testing:
Pharmacogenomic testing is required to identify genetic variants in enzymes (such as CYP450) and receptors that affect how the patient metabolizes specific medications. This data is essential for:
1. Determining the appropriate dosage to ensure efficacy.
2. Minimizing the risk of life-threatening adverse reactions.
3. Reducing the "trial and error" approach to prescribing, which has previously resulted in [mention failed outcomes/hospitalizations].

Requested Test:
[Insert Name of Laboratory and Specific Test/Panel]
CPT Codes: [Insert CPT Codes, e.g., 81225, 81226, 81401]

Based on the patient's clinical history and the failure of standard medication protocols, PGx testing is the most appropriate next step in providing safe and effective care. I request that you approve coverage for this diagnostic test.

Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

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