

Date: [Date]

To: [Insurance Company Name]

Attention: Appeals/Medical Review Department

Address: [Insurance Company Address]

RE: Letter of Medical Necessity for Custom Compounded Medication

Patient Name: [Patient Full Name]

Date of Birth: [DOB]

Policy Number: [Policy ID]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a formal coverage authorization for a custom compounded medication for the patient listed above. I have diagnosed the patient with [Diagnosis/ICD-10 Code].

Clinical Justification:

The patient has a documented severe allergy and/or hypersensitivity to the following inactive ingredients (excipients) found in commercially available versions of this medication: [List Allergens, e.g., Gluten, Lactose, Corn Starch, Specific Dyes].

Trial of Alternatives:

The patient has previously attempted to use the following FDA-approved commercial products:

- [Product Name 1]: Resulted in [Describe Adverse Reaction]
- [Product Name 2]: Resulted in [Describe Adverse Reaction]

Proposed Treatment:

Because no allergen-free commercial alternative exists, I have prescribed a custom compounded version of [Active Ingredient Name] that is strictly formulated without [Allergen]. This formulation is medically necessary to ensure the patient receives the required therapy without the risk of an allergic reaction or medical complications.

Please contact my office at [Phone Number] if you require additional medical records or documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]