

Date: [Date]

TO: [Insurance Company Name]

ATTN: Prior Authorization Department

FAX: [Fax Number]

RE: Letter of Medical Necessity for Compounded Transdermal Therapy

PATIENT INFORMATION:

Name: [Patient Name]

Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

Dear Medical Director,

I am writing to request a formal review and coverage for a customized compounded transdermal pain medication for the above-referenced patient. This patient is currently under my care for the treatment of [Diagnosis/ICD-10 Code].

Clinical Justification:

The patient has been diagnosed with chronic pain associated with [Specific Condition]. Traditional oral medications and commercially available topical treatments have proven inadequate or inappropriate for the following reasons:

- [Reason 1: e.g., Contraindication to systemic NSAIDs due to GI issues]
- [Reason 2: e.g., Failed trial of oral medications: List medications]
- [Reason 3: e.g., Difficulty swallowing or risk of systemic toxicity]

Requested Formulation:

The specific formulation required is: [List Ingredients and Strengths, e.g., Ketoprofen 10% / Cyclobenzaprine 2% / Gabapentin 6%].

Medical Necessity:

A compounded transdermal therapy is medically necessary for this patient because it allows for localized delivery of active ingredients directly to the site of pain, minimizing systemic absorption and reducing the risk of adverse drug events. No commercially available manufactured product contains the necessary combination or concentration of ingredients required to manage this patient's symptoms effectively.

I request that you approve this prescription to prevent further clinical decline and to improve the patient's functional status. Please contact my office at [Phone Number] if you require additional clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Clinic Name]