Date: [Insert Date]

To: [Insurance Company Name]
Attention: Prior Authorization Department
Fax/Address: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Custom Compounded Medication

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

To Whom It May Concern,

I am writing to request coverage for a custom pediatric liquid compounded suspension of [Name of Medication/Active Ingredient] for my patient, [Patient Name].

Diagnosis: [Insert ICD-10 Code and Diagnosis Name]

Clinical Justification:
The patient requires this medication for the treatment of the condition listed above. A custom compounded liquid suspension is medically necessary for the following reason(s):

- **Inability to Swallow:** The patient is a pediatric patient who cannot safely swallow commercially available solid dosage forms (tablets/capsules).
- **Dosage Requirement:** The required dose of [Insert Dose, e.g., 2.5mg] is not available in a commercial manufactured strength. Precision dosing is required based on the patient's current weight of [Insert Weight].
- **Alternative Failure:** Commercially available liquid alternatives are not available for this specific medication.
- **Allergy/Sensitivity:** The patient has a documented allergy or intolerance to [Insert Dye/Filler/Preservative] found in the mass-produced version.

Prescription Details:
Medication: [Insert Ingredient and Concentration]
Form: Oral Liquid Suspension
Directions: [Insert Sig/Instructions]
Duration: [Insert Length of Treatment]

Failure to provide this compounded medication puts the patient at risk for treatment non-compliance, choking hazards, or worsening of their medical condition.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[NPI Number]
[Practice Name]