

**Date:** [Date]

**To:** [Insurance Company Name]

**Attention:** Medical Review/Prior Authorization Department

**Fax/Address:** [Fax Number or Address]

**RE: Letter of Medical Necessity for Preservative-Free Compounded Ophthalmic Drops**

**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 coverage for a custom compounded preservative-free ophthalmic formulation for my patient, [Patient Name].

**Diagnosis:** [List Diagnoses, e.g., Severe Keratoconjunctivitis Sicca, Glaucoma, Recurrent Corneal Erosions, Chronic Blepharitis]

**Clinical Justification:**

The patient requires a preservative-free formulation due to the following clinical reasons:

- **Documented Sensitivity:** The patient has a known hypersensitivity or ocular surface toxicity to common preservatives, specifically Benzalkonium Chloride (BAK).
- **Treatment Frequency:** The patient requires dosing more than [X] times per day. Chronic exposure to preservatives at this frequency risks further damage to the corneal epithelium.
- **Failure of Standard Therapy:** The patient has previously tried and failed the following commercially available preserved medications: [List Medications Tried]. These resulted in [List Adverse Reactions, e.g., burning, increased inflammation, ocular surface breakdown].
- **Non-Availability:** There is no commercially available manufactured preservative-free alternative that meets the specific dosage and concentration requirements necessary for this patient's condition.

**Proposed Formulation:**

[Insert Exact Compounded Formula, e.g., Cyclosporin 0.05% Preservative-Free Ophthalmic Solution]

In summary, the use of this preservative-free compounded medication is medically necessary to prevent further ocular surface deterioration and to manage the patient's condition effectively. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]