

Date: [Insert Date]

TO: [Insurance Company Name]

ATTN: [Appeals/Prior Authorization Department]

FAX: [Fax Number]

RE: Letter of Medical Necessity for Multi-Ingredient Compounded Medication

Patient Name: [Patient Name]

Date of Birth: [DOB]

Policy ID: [Policy ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a formal coverage authorization for a customized multi-ingredient compounded dermatological cream for my patient, [Patient Name].

Diagnosis: [Insert Diagnosis, e.g., Severe Atopic Dermatitis, Psoriasis, Chronic Pruritus]

ICD-10 Code: [Insert Code]

Prescribed Formulation:

[List all active ingredients and percentages, e.g., Hydrocortisone 1% / Ketoconazole 2% / Aloe Vera in Vanicream base]

Clinical Justification:

The patient requires this specific combination therapy for the following reasons:

- **Commercial Failure:** The patient has failed treatment with the following mass-produced FDA-approved medications: [List previous medications].
- **Ingredient Requirement:** A combination of [Ingredient 1] and [Ingredient 2] is necessary to treat the inflammatory and infectious components of the condition simultaneously.
- **Allergy/Sensitivity:** The patient is allergic to [Insert Ingredient, e.g., Propylene Glycol] found in standard commercial equivalents.
- **Dosing Precision:** The required strength of [Ingredient] is not commercially available.

In my professional medical opinion, this compounded medication is medically necessary and is the most effective treatment for this patient's condition. Failure to provide this medication may result in [Insert potential complication].

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]
[Practice Name]