

Date: [Date]

To: [Insurance Company Name]

Attention: [Prior Authorization/Appeals Department]

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for Compounded Medication

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Member ID: [Insurance ID Number]

Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a formal coverage authorization for a customized compounded medication for my patient, [Patient Name]. This medication is medically necessary because the required formulation is commercially unavailable in a mass-produced, FDA-approved format.

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

Requested Formulation:

[Insert Medication Name, Strength, and Dosage Form, e.g., Omeprazole 2mg/mL Oral Suspension]

Reason for Compounding:

The patient requires this specific compounded formulation for the following reason(s):

- [Example: The patient is unable to swallow solid oral dosage forms (tablets/capsules).]
- [Example: The required strength/dosage is not manufactured commercially.]
- [Example: The patient has a documented allergy to an excipient (dye/filler) in the commercial version.]
- [Example: The patient requires a specific delivery method not available on the market.]

Previous Clinical Failures:

The patient has previously tried and failed the following commercially available alternatives:
[List Medications and outcomes/reactions].

Clinical Justification:

Without access to this specific compounded medication, the patient is at risk for [List potential complications or worsening of condition]. This customized formulation is the most appropriate clinical intervention for this patient's current medical state.

I request that you approve coverage for this compounded prescription. Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]