

Date: [Date]

TO: [Insurance Company Name]

ATTN: [Prior Authorization/Appeals Department]

FAX: [Fax Number]

RE: Letter of Medical Necessity for Compounded Suppositories

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 compounded rectal/vaginal suppository for the above-mentioned patient. I have determined that this alternate route of administration is medically necessary due to the patient's specific clinical requirements.

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

Medication Requested: [Active Ingredient Name] [Strength] Compounded Suppositories

Reason for Alternate Route:

The patient is unable to utilize commercially available oral or topical forms of this medication due to the following medical reason(s):

- [Example: Severe dysphagia or inability to swallow oral solids]
- [Example: Intractable nausea and vomiting preventing oral absorption]
- [Example: Gastrointestinal malabsorption or history of gastric bypass]
- [Example: Need for localized delivery to target tissue to minimize systemic side effects]
- [Example: Documented allergy to dyes or fillers in commercial formulations]

Clinical Justification:

The patient has previously tried and failed the following conventional therapies: [List failed medications]. Failure to provide this medication via the suppository route will likely result in [List potential complications or hospitalization].

I am requesting that you make an exception and cover this compounded medication to ensure the patient's stability and adherence to the treatment plan. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]
[Practice Name]