Date: [Insert Date]

TO: [Insurance Company Name]
ATTN: [Department/Claims Processing]
FAX/ADDRESS: [Insert Fax Number or Address]

RE: Letter of Medical Necessity for Compounded Gluten-Free Medication
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Insert Policy Number]
Group Number: [Insert Group Number]

To Whom It May Concern,

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

The patient has been diagnosed with:

- [Insert Diagnosis, e.g., Celiac Disease (ICD-10: K90.0)]
- [Insert Diagnosis, e.g., Dermatitis Herpetiformis (ICD-10: L13.0)]
- [Insert Diagnosis, e.g., Severe Non-Celiac Gluten Sensitivity]

The patient requires a compounded formulation because commercially available versions of this medication contain gluten-based excipients or are manufactured in facilities where cross-contamination with gluten cannot be ruled out. Due to the patient's medical condition, the ingestion of even trace amounts of gluten poses a significant health risk, including [list symptoms/risks, e.g., severe gastrointestinal distress, malabsorption, or systemic inflammation].

Therefore, it is medically necessary for this medication to be prepared by a compounding pharmacy to ensure it is 100% gluten-free and safe for the patient's consumption.

I request that you approve coverage for this compounded prescription as a medical necessity. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

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