[Date]
[Insurance Provider Name]
[Prior Authorization Department]
[Provider Address]
[City, State, Zip Code]

RE: Statement of Medical Necessity for Brand Name Medication

Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [If applicable]

To Whom It May Concern,

I am writing to request a formal review and coverage for the brand-name medication **[Brand Name Medication]** for the treatment of **[Patient's Diagnosis/ICD-10 Code]**. Based on the patient's medical history, the generic alternative is medically inappropriate.

Clinical Justification:

- **Failed Generic Trials:** The patient has previously trialed the generic version(s) [Name of Generic(s)] from [Start Date] to [End Date]. This trial resulted in [describe therapeutic failure or inadequate symptom control].
- **Adverse Reactions:** The patient experienced [describe specific side effects or allergic reactions] when taking the generic formulation, which are not present with the brand-name version.
- **Specific Formulation Needs:** The brand-name medication is necessary because [mention specific delivery system, inactive ingredients, or pharmacokinetic differences].

In my professional medical opinion, **[Brand Name Medication]** is medically necessary for this patient. Switching to or continuing with a generic alternative poses a significant risk to the patient's health and treatment stability.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]
[Phone Number]