Date: [Date]

To: [Insurance Provider/Pharmacy Benefit Manager Name]
Attention: [Prior Authorization Department/Appeals Department]
Fax/Address: [Fax Number or Mailing Address]

Subject: Letter of Medical Necessity for [Patient Name]

Patient Information:
Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [ID Number]
Group Number: [Group Number]

Dear Medical Director,

I am writing to provide clinical rationale for the use of **[Brand Name Medication]** for the treatment of **[Diagnosis/ICD-10 Code]**. Based on the patient's medical history, I am requesting a "Dispense as Written" (DAW) authorization as the generic alternative is medically inappropriate.

Clinical Justification:

- **Previous Treatment Failure:** The patient has previously trialed the generic version(s) [Generic Name] from [Start Date] to [End Date]. This resulted in [Inadequate Therapeutic Response/Treatment Failure].
- **Documented Adverse Reaction:** The patient experienced [Specific Side Effect or Allergic Reaction] when taking the generic formulation, which is not present when using the brand name version.
- **Bioavailability Concerns:** This patient requires precise titration. The variations in inactive ingredients or pharmacokinetic properties between the generic and brand versions pose a significant risk to the patient's stability.
- **Comorbidities:** [List any relevant comorbidities that make the brand name essential].

Requested Medication: [Brand Name]
Dosage: [Dosage]
Frequency: [Frequency]

In my professional clinical opinion, **[Brand Name Medication]** is medically necessary for this patient. Switching to a generic or formulary alternative would likely result in [Expected Negative Outcome].

Thank you for your immediate attention to this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

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