

[Physician Name]  
[Clinic Name]  
[Address]  
[Phone Number]  
[Date]

[Insurance Company Name]  
[Prior Authorization Department]  
[Address]

**RE: Letter of Medical Necessity for Off-Label Ketamine Treatment**

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

To Whom It May Concern,

I am writing to request coverage for [IV/IM/Sublingual] Ketamine treatments for [Patient Name] for the treatment of Major Depressive Disorder, recurrent, severe (ICD-10: F33.2). The patient has met the criteria for Treatment-Resistant Depression (TRD).

**Clinical History:**

[Patient Name] has been under my care since [Date]. Despite multiple standard interventions, the patient continues to suffer from debilitating symptoms including [List Symptoms: e.g., persistent low mood, suicidal ideation, inability to function].

**Previous Failed Treatments:**

The patient has failed adequate trials (at least 6-8 weeks) of the following medications and therapies:

- [Medication 1]: [Dose] - Result: [No response/Side effects]
- [Medication 2]: [Dose] - Result: [No response/Side effects]
- [Medication 3]: [Dose] - Result: [No response/Side effects]
- [Augmentation Strategy]: [e.g., Lithium or Abilify] - Result: [Failed]
- [Procedure]: [e.g., TMS or ECT] - Result: [Failed or Contraindicated]

**Rationale for Ketamine:**

Given the severity of the patient's condition and the failure of FDA-approved first- and second-line treatments, Ketamine is medically necessary. Although utilized off-label for this specific administration route, extensive clinical evidence and peer-reviewed studies support its efficacy in rapidly reducing depressive symptoms and suicidal ideation in treatment-resistant cases.

**Treatment Plan:**

I am recommending an initial induction phase of [Number] treatments over [Number] weeks, followed by a maintenance schedule based on clinical response.

I request that you approve this request to prevent further clinical deterioration or hospitalization. Please contact me at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]