

[Date]

**[Insurance Company Name]**

[Attn: Appeals/Medical Necessity Department]

[Insurance Address]

[City, State, Zip Code]

**RE: Letter of Medical Necessity for Off-Label Use of Azithromycin**

**Patient Name:** [Patient Name]

**Date of Birth:** [Patient DOB]

**Policy Number:** [Policy ID Number]

**Group Number:** [Group Number]

**Case Reference Number:** [Claim/Reference Number if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, **[Patient Name]**, to request coverage for Azithromycin (250mg) for the treatment of Refractory Chronic Cough (ICD-10 Code: R05.3). Although Azithromycin is an antibiotic, it is being prescribed here for its proven immunomodulatory and anti-inflammatory properties in managing persistent cough that has failed standard therapies.

**Clinical History:**

The patient has suffered from a persistent cough for **[Number]** months/years. Extensive diagnostic evaluations, including [list tests, e.g., chest X-ray, CT scan, spirometry, or methacholine challenge], have been performed to rule out underlying malignancy or infection.

**Failed Alternative Treatments:**

Standard treatments for common triggers (Asthma, GERD, and Post-Nasal Drip) have been exhausted without resolution of symptoms. Failed medications include:

- [Medication Name/Class, e.g., Inhaled Corticosteroids] - [Duration/Outcome]
- [Medication Name/Class, e.g., Proton Pump Inhibitors] - [Duration/Outcome]
- [Medication Name/Class, e.g., Neuromodulators/Gabapentin] - [Duration/Outcome]

**Medical Justification:**

Clinical evidence, including the COUGH-2 trial and guidelines from the American College of Chest Physicians (CHEST), supports the use of low-dose macrolides for patients with refractory chronic cough. In this case, Azithromycin is medically necessary to reduce cough frequency, improve quality of life, and prevent complications associated with chronic tussive force.

**Proposed Treatment Plan:**

I have prescribed Azithromycin [250mg] to be taken [three times per week] for a trial period of [duration, e.g., 3-6 months]. The patient will be monitored for clinical response and any potential side effects.

I request that you approve this request for off-label use based on the patient's clinical non-responsiveness to FDA-approved therapies for this condition. Please contact my office at [Phone Number] if you require further documentation.

Sincerely,

[Physician Signature]

**[Physician Name, MD/DO]**

[Medical Specialty]

[NPI Number]

[Practice Name]