[Physician Name, MD/DO]
[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]
[Date]

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

RE: Letter of Medical Necessity for Hydroxychloroquine (Off-label)

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing to formally request a formulary exception and coverage for Hydroxychloroquine (HCQ) for the treatment of Erosive Osteoarthritis (ICD-10: M15.4) for my patient, [Patient Name].

Clinical Diagnosis and Patient History:
The patient has been diagnosed with Erosive Osteoarthritis, a severe and aggressive form of inflammatory osteoarthritis characterized by subchondral erosions and significant joint destruction. The patient currently presents with [List symptoms: e.g., chronic pain, swelling, decreased range of motion] in the [List affected joints: e.g., PIP and DIP joints of the hands].

Previous Therapies and Failures:
The patient has failed to achieve adequate symptom control or has contraindications to standard therapies, including:

- [Therapy Name, e.g., Oral NSAIDs]: [Reason for failure/contraindication]
- [Therapy Name, e.g., Topical NSAIDs]: [Reason for failure/contraindication]
- [Therapy Name, e.g., Intra-articular Steroid Injections]: [Reason for failure/contraindication]

Medical Justification for Off-Label Use:
While Hydroxychloroquine is traditionally indicated for Rheumatoid Arthritis and SLE, there is a strong clinical rationale for its use in Erosive Osteoarthritis due to its anti-inflammatory and immunomodulatory properties. Given the inflammatory component of this patient's erosive disease, HCQ is being prescribed to mitigate joint destruction and manage systemic

inflammation where traditional OA treatments have failed. This treatment is necessary to prevent further irreversible joint damage and potential disability.

Proposed Treatment Plan:
I am prescribing Hydroxychloroquine [Dosage, e.g., 200mg or 400mg] daily. We will monitor the patient for clinical improvement and perform regular ophthalmic screenings as per standard safety protocols.

Based on the patient's clinical presentation and failure of conventional therapies, I request that you approve the use of Hydroxychloroquine for this medical necessity.

Please contact me at [Phone Number] if you require further documentation.

Sincerely,

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