

[Date]

[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Continuation of Therapy

Patient Name: [Patient First and Last Name]

Date of Birth: [MM/DD/YYYY]

Policy Number: [ID Number]

Group Number: [Group Number]

Medication Name: [Medication Name]

ICD-10 Code: [Diagnosis Code]

To Whom It May Concern,

I am writing to formally request the continued authorization and coverage for [Medication Name] for my patient, [Patient Name]. [Patient Name] has been under my care for [Diagnosis] since [Date].

Clinical History and Progress:

The patient began treatment with [Medication Name] on [Start Date]. Since initiating this therapy, the patient has shown significant clinical improvement, including:

- [List specific improvement, e.g., reduced lab markers]
- [List specific improvement, e.g., decreased frequency of symptoms]
- [List specific improvement, e.g., improved quality of life/functionality]

Previous Therapies:

Prior to this medication, the patient failed the following preferred or lower-cost alternatives:

- [Alternative 1]: [Reason for failure/contraindication]
- [Alternative 2]: [Reason for failure/contraindication]

Medical Necessity for Continuation:

At this time, [Medication Name] is medically necessary to maintain the patient's current health status and prevent disease progression. Any interruption in this specific therapy or a forced switch to a different medication poses a significant risk of [mention specific risks, e.g., relapse, hospitalization, or permanent organ damage].

Therefore, I request that you approve the continuation of [Medication Name] for the next [Number of months/year].

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]