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

RE: Letter of Medical Necessity for [Patient Name]
Patient DOB: [MM/DD/YYYY]
Member ID: [Member ID Number]
Group Number: [Group 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 the brand-name medication **[Brand Name Medication]** for the treatment of [Diagnosis/Condition, e.g., Epilepsy, Multiple Sclerosis, Parkinson's Disease] (ICD-10 Code: [Code]).

Clinical History:
[Patient Name] has been under my care for [Length of time]. The patient's condition is characterized by [Brief description of symptoms and severity].

Failed Medications/Contraindications:
The patient has previously attempted and failed the following therapeutic trials (including generic formulations):

- [Generic/Alternative Drug 1]: [Dates used], Reason for failure: [e.g., Lack of efficacy, severe side effects]
- [Generic/Alternative Drug 2]: [Dates used], Reason for failure: [e.g., Breakthrough seizures, allergic reaction]

Medical Justification for Brand Name:
[Provide specific clinical reason why the brand name is required, e.g., "The patient experienced breakthrough symptoms when transitioned to the generic," "The patient has a documented allergy to an excipient/filler in the generic version," or "Bioavailability fluctuations in generic versions pose a significant risk for this patient's neurological stability."]

Recommendation:
Based on the patient's clinical history and the risks associated with treatment failure in neurology, it is my professional opinion that [Brand Name Medication] is medically necessary. A switch to a generic or alternative therapeutic class would likely result in [List risks, e.g., hospitalization, permanent neurological deficit, loss of independence].

Please contact my office at [Phone Number] if any further documentation is required to approve this request.

Sincerely,

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