[Date]

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

RE: Letter of Medical Necessity for Off-Label Use
Patient Name: [Patient First and Last Name]
Date of Birth: [MM/DD/YYYY]
Policy Number: [Policy 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 formal authorization for the medication [Drug Name] for the treatment of [Diagnosis/Condition] (ICD-10 code: [Code]).

While [Drug Name] is FDA-approved for [FDA-Approved Indication], I am prescribing it off-label based on clinical evidence and the patient's specific medical history. [Patient Name] has been under my care since [Date] and has a diagnosis of [Condition], which is characterized by [Brief symptoms/severity].

Clinical Justification:
The patient has previously tried and failed the following formulary or FDA-approved treatments:

- [Previous Treatment A]: [Dates used/Results/Reason for discontinuation]
- [Previous Treatment B]: [Dates used/Results/Reason for discontinuation]

Supporting Evidence:
The use of [Drug Name] for [Condition] is supported by the following clinical peer-reviewed literature and/or medical compendia: [Cite specific studies, journals, or guidelines]. These studies demonstrate that [Drug Name] is effective in [mention specific outcome, e.g., reducing symptoms, preventing progression].

In my professional medical opinion, [Drug Name] is medically necessary for this patient as there are no other viable alternatives that provide the same level of efficacy and safety for their specific presentation. Delaying treatment poses a significant risk to the patient's health, including [List potential complications].

I request that you approve this request for [Drug Name] at a dosage of [Dosage/Frequency] for a duration of [Time period].

Thank you for your prompt attention to this matter. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[NPI Number]
[Clinic Name/Address]