

[Date]
[Insurance Company Name]
[Attn: Medical Review/Prior Authorization Department]
[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]

To Whom It May Concern,

I am writing to formally request coverage for [**Medication Name**] for my patient, [**Patient Name**]. Although this medication is being prescribed for an off-label indication, it is medically necessary for the treatment of [**Patient's Diagnosis/Condition**] (ICD-10 code: [Code]).

Patient History:

The patient has been under my care since [Date] for [Condition]. This condition is characterized by [Brief Description of Severity or Symptoms].

Previous Treatments:

The patient has previously failed the following FDA-approved therapies or standard-of-care treatments:

- [Drug Name 1]: [Reason for failure/side effects]
- [Drug Name 2]: [Reason for failure/side effects]

Clinical Justification:

I am prescribing [Medication Name] based on current clinical evidence and peer-reviewed literature. Specifically, [mention a specific study, clinical guideline, or compendia such as AHFS or Micromedex] demonstrates that this medication is effective for [Condition]. Given the patient's unique clinical profile, I believe this treatment is the most appropriate course of action to prevent [mention potential complications or disease progression].

Included with this letter, please find [list attachments, e.g., clinical notes, journal articles, or lab results] supporting this request. I ask that you approve this prior authorization to ensure the patient receives the necessary standard of care.

Please contact my office at [Phone Number] if you require further information.

Sincerely,

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

[Medical Specialty]
[NPI Number]
[Practice Name]