

[Date]

[Payer Name]

[Payer Address]

[City, State, Zip Code]

**RE: Letter of Medical Necessity for [Patient Name]**

**Patient Name:** [Patient Name]

**Date of Birth:** [DOB]

**Member ID:** [Member ID Number]

**Group Number:** [Group Number]

**Case Number:** [Case ID, if applicable]

Dear Medical Review Manager,

I am writing to request coverage for [**Targeted Therapy Drug Name**] for the treatment of [**Patient Name**], who is under my care for [**Specific Cancer Diagnosis**] (ICD-10 code: [**Code**]).

**Clinical Background:**

The patient was diagnosed with [**Stage/Type of Cancer**] on [**Date**]. The patient's clinical history includes:

- [Brief summary of clinical presentation]
- [Previous treatments and outcomes, e.g., chemotherapy, surgery, radiation]
- [Reason for discontinuation of previous therapies]

**Medical Necessity and Biomarker Data:**

The use of [**Targeted Therapy Drug Name**] is medically necessary based on specific molecular testing results. Genomic testing performed on [**Date**] by [**Lab Name**] confirmed the presence of:

- [**Specific Mutation/Biomarker, e.g., EGFR, ALK, HER2, BRAF**]

Current clinical guidelines, including [**NCCN/ASCO**], recommend the use of [**Targeted Therapy Drug Name**] for patients with this specific molecular profile. This therapy is designed to inhibit [**Mechanism of Action**], which is the primary driver of this patient's malignancy.

**Treatment Plan:**

The patient will receive [**Dosage**] of [**Targeted Therapy Drug Name**] administered [**Frequency**]. I expect this treatment to [**Expected Outcome, e.g., prolong progression-free survival, reduce tumor burden**].

In summary, [**Targeted Therapy Drug Name**] is the most appropriate treatment for [**Patient Name**] given their specific genetic markers and treatment history. I request that you approve coverage for this life-sustaining therapy.

Please contact me at **[Phone Number]** if you require additional information.

Sincerely,

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

**Enclosures:**

[Pathology Report]  
[Molecular/Genomic Testing Results]  
[Clinical Progress Notes]  
[Prescribing Information/FDA Approval Letter]