

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

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

Patient Date of Birth: [DOB]  
Policy Number: [Policy ID]  
Group Number: [Group Number]  
Claim/Reference Number: [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to document the medical necessity of **[Name of Specialty Medication]** for the treatment of [Specific Type of MS, e.g., Relapsing-Remitting Multiple Sclerosis].

**Patient Clinical History:**

[Patient Name] was diagnosed with Multiple Sclerosis on [Date of Diagnosis]. The patient currently presents with symptoms including [list symptoms, e.g., optic neuritis, fatigue, gait imbalance, numbness]. MRI results from [Date] indicate [mention specific lesions or disease activity].

**Previous Therapies Attempted:**

The patient has previously tried the following Disease-Modifying Therapies (DMTs):

- [Medication A]: Tried from [Date] to [Date]. Outcome: [e.g., Treatment failure, intolerable side effects, or new lesion growth].
- [Medication B]: Tried from [Date] to [Date]. Outcome: [e.g., Inadequate response or allergic reaction].

**Rationale for Treatment:**

Based on the patient's clinical progression and the failure of previous therapies, I am prescribing [Name of Specialty Medication]. This medication is essential to [prevent further neurological disability / reduce the frequency of relapses / slow the progression of physical disability]. Delaying treatment with this specific agent poses a significant risk to the patient's long-term health and mobility.

In my professional medical opinion, [Name of Specialty Medication] is the most appropriate and medically necessary course of action for [Patient Name] at this time. I request that you approve coverage for this treatment immediately.

Please contact my office at [Phone Number] if you require additional clinical documentation or have further questions.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Specialty]

[NPI Number]

[Practice Name]