

**Date:** [Date]

**To:** [Insurance Company Name]

**Attention:** Medical Review Department / Prior Authorization Department

**Fax/Address:** [Fax Number or Mailing Address]

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

**Date of Birth:** [DOB]

**Policy Number:** [Policy ID]

**Group Number:** [Group Number]

**Claim/Reference Number:** [Reference Number if applicable]

Dear Medical Director,

I am writing to request authorization for the use of [**Name of Biologic Medication**] for my patient, [Patient Name], who has been diagnosed with **Severe Eosinophilic Asthma (ICD-10: J45.50)**.

**Clinical Documentation:**

The patient meets the clinical criteria for severe eosinophilic asthma as evidenced by:

- **Eosinophil Count:** [Count] cells/mcL, measured on [Date].
- **Exacerbation History:** The patient has experienced [Number] exacerbations requiring systemic corticosteroids in the past 12 months.
- **Symptom Control:** Despite adherence to high-dose inhaled corticosteroids (ICS) and long-acting beta-agonists (LABA), the patient remains symptomatic with frequent [shortness of breath/nighttime awakenings/wheezing].

**Previous Therapies Attempted and Failed:**

- [Drug Name 1]: [Duration of Use]. Reason for failure: [e.g., Inadequate symptom control].
- [Drug Name 2]: [Duration of Use]. Reason for failure: [e.g., Continued exacerbations].
- Systemic Corticosteroids: [Details of frequency or dependency].

**Treatment Plan:**

Based on the patient's persistent eosinophilic airway inflammation and history of severe exacerbations, I am prescribing [**Name of Biologic Medication**] at a dose of [Dose] to be administered [Frequency]. This treatment is medically necessary to reduce the risk of life-threatening asthma attacks and decrease the patient's reliance on systemic steroids.

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

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Clinic/Hospital Name]

[Phone Number]