

[Date]

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

Re: Letter of Medical Necessity for Hepatitis C Treatment

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to request a formal prior authorization for [Medication Name] for the treatment of Chronic Hepatitis C (HCV) for the above-referenced patient. This medication is medically necessary based on the patient's clinical history and diagnostic results.

Clinical Assessment:

The patient has been diagnosed with Chronic Hepatitis C, Genotype [Insert Genotype]. Recent laboratory testing confirms a viral load (HCV RNA) of [Insert Viral Load] IU/mL as of [Date].

Liver Fibrosis Status:

Evaluation of liver health via [Fibroscan/Liver Biopsy/APRI Score] indicates a fibrosis stage of [Insert Stage, e.g., F2, F3, F4]. Treatment is required to prevent progression to cirrhosis, hepatocellular carcinoma, and end-stage liver disease.

Treatment Rationale:

[Medication Name] is the current standard of care for this genotype. The patient [has/has not] previously failed prior HCV therapies. There are no contraindications to this therapy. A [12-week/8-week] course of treatment is requested to achieve a Sustained Virologic Response (SVR), which is considered a clinical cure.

Attached are the following supporting documents:

- HCV RNA Lab Results
- Genotype Lab Results
- Hepatic Fibrosis Assessment
- Relevant Clinical Progress Notes

Please expedite this request to ensure timely access to life-saving medication. If you require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]