

**Date:** [Date]

**TO:** [Specialty Pharmacy/Insurance Company Name]

**ATTN:** Prior Authorization Department

**FAX:** [Fax Number]

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

**DOB:** [Patient Date of Birth]

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

**Group Number:** [Group Number]

**Prescribed Medication:** [Drug Name, Dosage, Frequency]

**Diagnosis:** [Select: Heterozygous (HeFH) OR Homozygous (HoFH)] Familial Hypercholesterolemia

**ICD-10 Code:** [e.g., E78.01]

To Whom It May Concern,

I am writing to support the medical necessity of [Drug Name] for the treatment of Familial Hypercholesterolemia (FH) for the above-mentioned patient. This patient is under my care for the management of high-risk atherosclerotic cardiovascular disease (ASCVD) and severe genetic hyperlipidemia.

**Clinical History and Diagnosis:**

The patient has a confirmed diagnosis of FH based on [Clinical Criteria, e.g., Dutch Lipid Clinic Network Criteria score or Genetic Testing]. Despite adherence to lifestyle modifications and maximally tolerated lipid-lowering therapies, the patient's LDL-C levels remain significantly above the recommended target of [Target LDL-C, e.g.,

**Current Clinical Metrics:**

- Baseline LDL-C: [Value] mg/dL

- Most Recent LDL-C: [Value] mg/dL (as of [Date])

- Other Cardiovascular Risk Factors: [e.g., Hypertension, History of MI, Family History of premature CAD]

**Previous Therapies Attempted and Failed:**

1. [Statin Name & Dose]: [Duration] - [Result: e.g., Inadequate response or Intolerance]

2. [Statin Name & Dose]: [Duration] - [Result]

3. [Ezetimibe]: [Duration] - [Result]

4. [Other Therapy]: [Duration] - [Result]

**Medical Justification:**

Standard therapies have proven insufficient to lower this patient's LDL-C to safe levels. Given the patient's genetic predisposition to premature cardiovascular events, the addition of [Drug Name] is essential to reduce their high risk of myocardial infarction, stroke, and cardiovascular

death. [Drug Name] is FDA-approved for this diagnosis and is the clinically appropriate next step in treatment.

Please approve this request for [Drug Name] to ensure the patient receives the necessary standard of care. If you require additional documentation, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]

[Phone Number]