

[Date]
[Insurance Company Name]
[Attn: Medical Review/Appeals Department]
[Insurance Company Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for Intravenous Immunoglobulin (IVIG) Therapy

Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Policy Number: [Policy ID Number]
Group Number: [Group Number]
Claim/Reference Number: [If applicable]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name], to request authorization for Intravenous Immunoglobulin (IVIG) therapy (HCPCS Code: [Insert Code, e.g., J1561, J1569]). [Patient Name] has been under my care for the treatment of [Primary Diagnosis Name] (ICD-10 Code: [Insert Code]).

Clinical Background:

The patient was diagnosed with [Diagnosis] on [Date]. Clinical presentation includes [List symptoms, e.g., recurrent infections, muscle weakness, neurological deficits].

Diagnostic Evidence:

This diagnosis is confirmed by the following laboratory results and clinical findings:

- [Lab Result 1: e.g., IgG levels, antibody titers]
- [Lab Result 2: e.g., Electromyography (EMG), nerve biopsy]
- [Clinical Finding: e.g., Frequency of hospitalizations, failed physical exams]

Previous Treatments:

The patient has previously attempted the following therapies which were unsuccessful or contraindicated:

- [Treatment 1]: [Result/Reason for discontinuation]
- [Treatment 2]: [Result/Reason for discontinuation]

Treatment Plan:

I am prescribing IVIG therapy at a dose of [Dosage, e.g., 2g/kg body weight] to be administered [Frequency, e.g., every 4 weeks] for a period of [Duration, e.g., 6 months].

Medical Necessity:

IVIG is medically necessary for this patient to [State Goal: e.g., prevent life-threatening infections, stop disease progression, or improve functional mobility]. Given the patient's history and the severity of their condition, IVIG is the standard of care and essential for their long-term health outcomes.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Specialty]

[NPI Number]

[Practice Name]