Sample Letter of Medical Necessity

This sample letter is intended to provide an example of the types of information that may be included when responding to a request from a patient's insurance company to provide a letter of medical necessity for a Mitsubishi Tanabe Pharma America, Inc. medication you seek to prescribe. Use of the information in this letter does not guarantee that the health plan will provide reimbursement for the medication. Use of this sample letter is completely voluntary by the healthcare provider and/or patient and is not intended to be a substitute for, or to influence, the independent medical judgment of the physician.

Helpful Tips

- You may consider including a letter of medical necessity (like the example on page 2 of this document) with your prior authorization request to emphasize the medical necessity for a medication or in addition to your appeal letter, as needed
- A letter of medical necessity should be signed by the **physician only**
- Be sure to include an appropriate *International Classification of Diseases, Tenth or Eleventh Revision, Clinical Modification* (ICD-10-CM or ICD-11-CM) that matches your patient's diagnosis
- When you download this document, make certain to delete page 1 of this document

Example Checklist Summary

- ❑ Example chart notes
  - Date of initial diagnosis
  - Reason for the medication or treatment
  - Recommended treatment plan
  - Pertinent laboratory, diagnostic, and imaging tests and results
  - Patient's clinical response
  - Brief description of the patient's recent symptoms and conditions
  - Previous therapies the patient has undergone for the symptoms associated with their condition and the patient's response to these therapies
- ❑ A copy of the Prescribing Information for the medication

Sample Format Letter of Medical Necessity

[Insert Your Practice/Physician Letterhead]

Attn: [Insert Medical Director Name]

RE: [Insert Patient Name]
[Insert Name of Insurance Company]
[Insert Address]
[Insert City, State ZIP Code]

DOB: [Insert Patient Date of Birth]
Policy Number: [Insert Patient Policy Number]
Claim Number: [Insert Patient Claim Number]

[Date]

Dear [Insert Contact Name]:

[Insert Patient Name] has been under my care for [Insert Diagnosis] [Insert ICD-10-CM or ICD-11-CM code] since [Insert Date]. Treatment of [Insert Patient Name] with [medication] is medically appropriate and necessary and should be covered and reimbursed. This letter outlines my conclusion of medical necessity for [medication] and provides details about [Insert Patient Name]'s medical history, prognosis, and treatment rationale for [medication]. A copy of the Prescribing Information for [medication], which is indicated for this condition, is enclosed for your convenience.

[NOTE: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition. You may want to include:]

Summary of Patient's Medical History:

- [Patient's diagnosis, date of diagnosis, condition, and history]
- [Previous therapies used for treating the symptoms associated with the condition]
- [Patient's response to these therapies]
- [Brief description of the patient's recent symptoms and conditions]
- [Summary of your professional opinion of the patient's prognosis and need for medication]

Rationale for Treatment

[NOTE: This section should include your clinical rationale and reasons for urgency for the patient's treatment with medication. You may consider the following:]

Facts about [medication]

- [Medication is approved for the treatment of {Insert Diagnosis}. The FDA-approved label should be the primary basis for the criteria used to determine insurance coverage.]
- [Medical literature regarding the use of medication for diagnosis; {insert ICD-10-CM or ICD-11-CM code}.]
- [Insert summary statement for rationale for treatment such as: Considering the patient's history, condition, and the full Prescribing Information supporting uses of medication, I believe treatment with {medication} is medically necessary and should be a covered and reimbursed service.]
- [Documents that provide additional clinical information to support the recommendation for {medication} for this patient, such as peer-reviewed journal articles or clinical guidelines.]
- [Relevant clinical documentation such as history and physical, progress notes, treatment history, and outcomes, if supportive.]
- [The most common side effects of {medication}.]

About the Disease/Condition

- [Information related to the diagnosis.]

Please call my office at [Insert primary phone number] if I can be of further assistance or you require additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Insert Physician Name and Participating Provider Number]

Enclosure:
[Insert a PDF of the Prescribing Information for medication]

For US audiences only.
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CP-MTPA-US-0427 01/25