

Letter of Medical Necessity Template

Use of this document does not guarantee coverage for your patient. This document is intended to provide you with an example of the type of information that is typically required when providing a letter of medical necessity. The contents of your letter must be based on your medical judgement and align with the patient's medical records. Content below contained in brackets is intended for guidance only and should be replaced with appropriate patient-specific information before sending your customized letter to your patient's insurance provider.

[Payer name]

[Payer address]

[Payer fax, if needed]

Member name: [Name]

Member date of birth: [MM/DD/YYYY]

Subscriber number: [Subscriber number]

Group number: [Group number]

Request for approval of BEQALZI™ (sonrotoclax)

Dear [Medical Reviewer name],

I am writing to [request prior authorization/document medical necessity] for my patient, [Patient name]. I have prescribed BEQALZI as a treatment for [add diagnosis, ICD-10 code, and description]. This letter provides details of the patient's medical history and rationale for treatment.

Patient's medical history:

[Provide brief clinical description of patient, rationale for using BEQALZI, and treatment history. List all current and past therapies.]

Thank you for your consideration of this request. I look forward to your prompt review.

Sincerely,

[Physician signature]

[Physician name]

Attachments for review: [Add other supporting documentation, if applicable.]