Instructions:

This template is offered as a resource a healthcare provider could use when responding to a request from a patient's health benefits company to provide a letter of medical necessity for prescribing AstraZeneca or MedImmune medicines. **Attachments to be included with the letter of medical necessity are [original claim form, copy of denial or explanation of benefits, and any other additional supporting documents.]** If you need additional references, please contact our information center at 1-800-236-9933.

Use of the letter does not guarantee that the insurance company will provide reimbursement for AstraZeneca or MedImmune medicines, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Medical Necessity

(Healthcare Provider Letterhead)

Date: [Date]
Payor Name: [Payer Name]
Payor Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payor Phone and Fax Number: [Payer Phone and Fax Number]

Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]

Dear [Name of the Contact Person at the Insurance Company]:

I am writing on behalf of my patient, [Patient Name] to document the medical necessity of [Drug Name] for the treatment of [Specific Diagnosis]. This letter provides information about the patients' medical history and diagnosis and a statement summarizing my treatment rationale.

Patient History and Diagnosis
[Provide a Brief Description of the Patient's Medical Condition Here.]
[Include a Short Summary of the Patient's Medical History including lab results and failed medicines as applicable.]
[Explain why you believe it is Medically Necessary for Patient to receive this Medicine.]
[Describe the Potential Consequences of the Patient if they do not receive this Medicine.]
[Obtain and Attach Supporting Letters from any other Specialist(s) that is currently or has previously provided Care to the Patient.]
[Include Medicine Indication Information]
[Include Medicine Administration Information]

To conclude, [Medicine Name] is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of [Drug Name].

Sincerely,

[Physician's Name]
[Physician's Practice Name]

References
[Include medicine PI]
[Include other relevant references and publications regarding medicine]