Letter of Medical Necessity Template Instructions



# A Letter of Medical Necessity may be helpful to patients in the following situations:

* When an initial request for coverage is denied
* When a patient needs a product that would normally be subject to step therapy or prior authorization
* When a product is prescribed that is not routinely available within a payer’s formulary or is only available at a higher copay tier
* If a payer requires healthcare providers to support a prescription with additional information to ensure patient access to therapy

# Payers vary in their requirements for determining medical necessity. The following page is a template letter that healthcare providers can cut and paste onto their office letterhead. The letter includes the type of information that payers may require to establish medical necessity, such as:

* The patient’s diagnosis, condition, and medical history
* Information about your patient’s previous therapies and his/her response to those therapies
* A summary of your opinion about the patient’s prognosis without treatment
* Other documentation that supports your position

# Please note that this template is intended only as an example. Teva recommends confirming the information that is required to include in a medical necessity letter with individual payers.

©2022 Teva Neuroscience, Inc. COP-46768 December 2022

*Physician Letterhead*

[Insurance Company] Patient: [Patient’s first and last name]

[Address Line 1] Patient DOB: [Patient’s date of birth]

[Address Line 2] Policy ID: [Insurance ID #]

Policy Group: [Insurance Group #]

[Date]

Re: COPAXONE® (glatiramer acetate injection) coverage

Dear: [Payer Contact Name, Medical/Pharmacy Director], [Department]

I am writing on behalf of my patient, [patient’s name], born [date of birth], who has a diagnosis of [Multiple Sclerosis, G35] to formally document the medical necessity for treatment with COPAXONE® [20 mg/mL or 40 mg/mL]. This letter provides information about the patient’s medical history, diagnosis, and treatment plan with COPAXONE®.

**Patient’s Medical History and Treatment Rationale:**

* Patient’s medical history, diagnosis, and current condition (eg, signs, symptoms, functioning): [Provide a brief statement about the patient’s diagnosis and medical history, including any underlying health issues that affect your treatment selection]
* Prior treatments and response to those treatments: [If applicable, provide a list of current and past medications, as well as reasons for not prescribing a medication (eg, contraindications, drug interactions, lack of efficacy) and a summary of the patient’s experience with each medication, including clinical outcome, adverse drug reactions, and length of therapy]
* [Include a summary of why, based on your clinical judgment, your patient requires treatment with COPAXONE®]

**Summary of Rationale for Treatment:**

In summary, considering the patient’s history, condition, and the full Prescribing Information, use of COPAXONE® at this time is appropriate and medically necessary.

Please contact my office at [office phone number] if any additional information is required.

Sincerely, [Physician’s name]

Include enclosures as appropriate, such as excerpts from the patient’s medical record, relevant treatment guidelines, COPAXONE® Prescribing Information, and relevant clinical data