***Cover Letter for Sample Letter of Medical Necessity***

***for a Patient to Remain on Treatment***

**The following pages may be customized to use as a letter of medical necessity for a**

**patient to remain on disease-modifying therapy for relapsing multiple sclerosis.**

The following sample letter is intended to be used as a guide; therefore, it is important to tailor the letter to the specific needs of your patients and address the reason(s) why the prescribed disease-modifying therapy is the appropriate treatment option. You should always include pertinent clinical information that supports your decision.

Please see below for considerations when writing a letter of medical necessity:

* Review the health plan’s medical policy criteria and point out the criteria that your patient meets. Explain why your patient should be excluded from any criteria that he/she/they do(es) not meet
* Provide background on your patient’s condition and clearly state your patient’s individual circumstances to justify why continuation of the prescribed therapy is the appropriate choice
* Provide clinical justification, such as clinical response while on disease-modifying therapy, and include copies of relevant clinical data to support your decision (e.g., chart notes, MRI data, etc.)
* Submit the letter as required by the health plan and state guidelines. It is important that you understand the process for each health plan, including how to submit the request (fax, phone, email, the company’s website, etc.) as well as how and when the decision will be communicated
* Track the status of your request and follow up with the health plan as needed

[Insert Date]

Request for My Patient to Remain on [Insert Drug Name (generic)] for Relapsing Multiple Sclerosis (RMS)

RE: [Patient Name]

[Patient Insurance ID Number]

[Patient Date of Birth]

[Reference number]

Dear [Health Plan Contact Name]:

I am writing this letter of medical necessity in support of my request to continue treating [Patient Name] with [Drug Name (generic)], a United States Food and Drug Administration (FDA)-approved therapy indicated for the treatment of patients with relapsing forms of multiple sclerosis (RMS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. The full prescribing information for [Drug Name] can be accessed at [insert hyperlink to prescribed disease-modifying therapy’s PI].

As a board-certified [field of certification] with [XX] years of experience treating MS, I believe that the RMS medication[s] preferred by your coverage policy [is/are] not appropriate for my patient’s MS. Utilizing [name of product(s)] instead of [Drug Name] is not appropriate for [him/her/them] because [list reason(s) medication(s) are not appropriate such as safety, efficacy, contraindications, tolerability, route of administration, etc.]. [HCP to state the number of years they have been treating the patient and their opinion on the necessity of treating with the prescribed therapy].

[The previous disease-modifying [therapy/therapies] for this patient include:]

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Strength** | **Dates of Therapy** | **Reason for Failure/Discontinuation or Contraindications** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

I have evaluated my patient’s clinical response to [Drug Name] and have provided a summary below:

* [Date of diagnosis and ICD-10 code(s)]
* [Magnetic resonance imaging (MRI) data]
* [Physical disability, including description and related test results (e.g., Expanded Disability Status Scale (EDSS) score)]
* [History of relapse(s), including dates and symptoms]
* [Pertinent laboratory values]
* [Other pertinent clinical data indicating response to the prescribed disease-modifying therapy, such as
	1. Experienced stabilization, slowed progression, or improvement in at least 1 symptom such as motor function, fatigue, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation]

[HCP to insert the reasons for recommendation to use the prescribed therapy, which may include:]

* [Reason(s) [Drug Name] is most appropriate for this patient, such as efficacy profile of this product, safety and tolerability profile of this product, pharmacokinetic profile, dosage, and/or route of administration]
* [Additional reason(s) why [Drug Name] is the most appropriate treatment for this patient based on medical history and comorbidities (heart disease, hypertension, liver disease, etc.), MRI data, history of relapses, or EDSS history]

I ask that you review any clinical information submitted regarding my patient when considering this request, as well as review clinical guidelines and recent clinical trial results. I have indicated the additional information submitted with this letter below:

[[ ]  Relevant medication history and/or chart notes describing previous therapies and specific outcomes]

[[ ]  MRI data]

[[ ]  Patient’s history of relapses]

[[ ]  EDSS history]

[[ ]  Screening test results]

[[ ]  Supporting literature (eg, clinical guidelines, recent clinical trials, etc)]

In summary, based on my patient’s current condition and the clinical data available to date, continuing [Patient Name] on treatment with [Drug Name] is medically appropriate and necessary.

Please feel free to contact me if you require further information regarding this request. I look forward to your response as soon as possible.

Sincerely,

[Prescriber Name]

[Prescriber Specialty]

[Prescriber Contact Info]