SAMPLE LETTER OF MEDICAL NECESSITY

TELEPHONE: 1-844-496-8707 **FAX:** 1-877-548-1734 **HOURS:** 8:00 AM TO 8:00 PM ET, M-F

PFIZER DERMATOLOGY patient access™

[Physician Letterhead]

Attn: [Medical Director]
[Insurance Company]
[Address]
[City, State, ZIP code]

RE: [Patient Name]
[Date of Birth]
[Policy Number]
[Claim Number]

Request: Authorization for treatment with [Drug Name]
Diagnosis: [Diagnosis and ICD-10 code]
Dosage: [Dose & Frequency]

[Date]
Dear [Insert name],
I am writing on behalf of my patient, [Patient Name], to document the medical necessity of [Drug Name], which is indicated for the treatment of [Drug's indication].
This request is supported by the following information:

Summary of Patient's History

- [Patient's diagnosis, date of diagnosis]
- [Laboratory results and date]
- [Brief description of patient's current medical condition]
- [Patient's previous and current treatments/therapies]
- [Patient's response to those treatments/therapies]
- [If the patient has discontinued, include information on lack of response or tolerability]

Rationale for Treatment

Considering the patient's medical history, current medical condition, and the supporting uses of [Drug Name], I believe treatment with [Drug Name] at this time is warranted, appropriate, and medically necessary for this patient.

The following documentation is enclosed:

- [Drug Name] full Prescribing Information
- [Medical literature regarding the use of Drug Name for Diagnosis name; ICD-10 Code]
- [Relevant clinical documentation such as history and physical, progress notes, treatment history, and outcomes, if supportive]

Please call my office at [telephone number] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,
[Insert physician name and participating provider number]
Enclosures

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

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