

Sample Letter of Medical Necessity for TREANDA

Some payers may require the physician to submit a Letter of Medical Necessity (LMN) to support coverage of **TREANDA** therapy for a patient. The following sample letter may be used to document medical necessity and support coverage of **TREANDA**. This letter should be customized for each patient.

Date: _____
Contact: _____
Title: _____
Health Insurance Company: _____
Address: _____
City, State Zip Code: _____

Insured: [Name]
Policy Number: [Number]
Group Number: [Number]

SAMPLE

Dear [name or contact]:

I am writing on behalf of my patient, [patient name], to document medical necessity and request insurance coverage for **TREANDA** therapy. This letter provides information on the patient's condition, medical history and treatment rationale, as well as evidenced-based literature demonstrating medical necessity for the **TREANDA**.

Patient History and Diagnosis

[Patient name] is a [age] year old [male/female] with a diagnosis of [diagnosis and ICD-9-CM code] as of [date]. [Patient name] has been in [my or treating physician's name] care for [patient's diagnosis] since [date]. [Provide a brief discussion of patient's condition/symptoms and therapy to date, including examinations and diagnostic tests performed, other treatments attempted and results].

[Provide a brief discussion of **TREANDA** including supportive documentation and up-to-date, reference-based, peer-reviewed literature].

Based on the above facts, I am confident you will agree **TREANDA** therapy is a medically necessary and clinically appropriate treatment for this patient. If you have any further questions or require additional documentation, please feel free to call me at [physician telephone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician name]
[Physician Practice name]
[NPI number or provider number]