

## 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 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 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]

Payer Name: [Payer Name]

Payer Address: [Payer Address]

City, State, ZIP Code: [City, State, ZIP Code]

Payer 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]