

Sample Letter of Medical Necessity

[Date]

[Contact name of medical director or other payer representative]

[Contact title]

[Name of health insurance company]

[Address]

[City, State, Zip]

Re: Letter of Medical Necessity for XERMELO™ (telotristat ethyl)

Patient: **[Patient name]**

Group/policy number: **[Number]**

Date(s) of service: **[Dates]**

Diagnosis: **[Code & description]**

Dear **[Contact name or department]**:

I am writing on behalf of my patient, **[patient name]**, to document the medical necessity of XERMELO™ (telotristat ethyl) for the treatment of **[indication]**. This letter provides information about the patient's medical history and diagnosis, as well as a statement summarizing my treatment rationale.

[Patient name] has been treated for **[condition]** since **[date]**. **[Provide a brief medical history emphasizing the most recent events that directly influence your decision to recommend the necessary therapy]**.

In conclusion, XERMELO is medically necessary for this patient's medical condition. Please do not hesitate to contact me at **[physician's telephone number]** if you require any further information to approve this request.

Sincerely,

[Physician name] [Degree initials]

[Provider identification number]

Enclosures: **[Attach as appropriate]**