Sample Letter of Prior Authorization

[Date]
[Contact name of medical director or other payer representative]
[Contact title]
[Name of health insurance company]
[Address]
[City, State, Zip]
Re: Appeal for Prior Authorization 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 request prior authorization for the use of XERMELO™ (telotristat ethyl) for the treatment of **[indication]**.

Information related to the patient's medical history, prognosis, and treatment rationale are summarized below.
[Insert a narrative of the patient's medical history, including:]

- **[Patient's diagnosis, condition, and treatment history]**
- **[Previous therapies the patient has undergone for the disease symptoms]**
- **[Patient's response to past tried and failed therapies]**
- **[Brief description of the patient's recent symptoms and conditions]**

[Summarize your professional opinion of the patient's likely prognosis or disease progression without treatment with XERMELO].

Given **[patient name]**'s medical history and the indication for XERMELO, I am confident you will agree that XERMELO is medically necessary for my patient. Please do not hesitate to contact me at **[physician's telephone number]** if you require any further information to approve this request.

Sincerely,
[Provider name] [Degree initials]
[Provider identification number]

Enclosures: **[Attach as appropriate]**