Sample Letter of Medical Necessity

[Date]

[Name of Health Insurance Company]

[Attn:]

[Address]

[City, State, Zip]

Re: Letter of Medical Necessity for Tirosint-SOL (levothyroxine sodium) oral solution

Patient: [Patient Name]

Group/policy Number: [Number]

Date(s) of service: [Dates]

Diagnosis: [Code & Description]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to document medical necessity for treatment with Tirosint-SOL.

Tirosint-SOL has received approval for the treatment of the following two indications in children and adults:

- Hypothyroidism- As a replacement therapy in primary (thyroidal), secondary (pituitary) and tertiary (hypothalamic) congenital or acquired hypothyroidism
- Pituitary Thyrotropin (Thyroid-Stimulating Hormone, TSH) Suppression- As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer

Tirosint-SOL is a liquid formulation of levothyroxine available in 15 dosage strengths (13,25,37.5,44,50, 62.5, 75, 88, 100, 112, 125, 137, 150, 175 and 200 mcg). It is packaged in unit dose ampules which are available in 30-day supplies.

This letter serves to document that [PATIENT NAME] has a diagnosis of [DIAGNOSIS) and needs treatment with Tirosint-SOL and that Tirosint-SOL is medically necessary for {him/her] as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatment.

Patient Medical History and Diagnosis:

[PATIENT NAME] is a [AGE] year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY).

Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatment with Tirosint-SOL.