SAMPLE Letter of Medical Necessity
For Aranesp® (darbepoetin alfa) Nephrology

Date

Payor Name
Payor Representative
Payor Address
City, State, ZIP Code
Payor Fax Number

Attn: Payor Representative
Attn: Department Name (optional)

Re: Coverage of Aranesp® (darbepoetin alfa)
Subscriber's First and Last Name
Patient's First and Last Name
Policy # / Patient's ID
Group #
Patient Date of Birth
Patient Age
Patient Sex

Dear (Salutation) Medical or Pharmacy Director:

I am writing on behalf of ***{patient name}***, ***{policy number}*** to document the medical necessity of Aranesp® (darbepoetin alfa).

Aranesp® is indicated for the treatment of anemia associated with chronic renal failure (CRF). The full prescribing information, including **Boxed WARNINGS** and Medication guide, for Aranesp® can be accessed at www.aranesp.com.

Mr/Mrs/Ms ***{patient's last name}***'s medical history and course of treatment are as follows:

- **Describe the patient's history, diagnosis, previous and current treatment regimens and their outcomes.**

In my clinical opinion, Mr/Mrs/Ms ***{patient's last name}*** should receive Aranesp® for the following reasons.

- **List reasons**

In summary, Aranesp® is medically necessary and reasonable for Mr/Mrs/Ms ***{patient's last name}***'s medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,

{Physician Name}