CRESEMBA® (isavuconazonium sulfate) 372 mg for injection · 186 mg capsules
SUPPORT SOLUTIONS℠

SAMPLE Letter of Medical Necessity For CRESEMBA® (isavuconazonium sulfate)

Date
Payer Name
Payer Address
City, State, ZIP Code
Payer Fax Number

Attn: Payer Representative
Department Name (optional)

Re: Coverage of **CRESEMBA**
Patient's First and Last Name
Policy Number / Patient's ID
Group Number
Patient Date of Birth

Dear Medical or Pharmacy Director:

I am writing on behalf of ***[patient name], [policy number]*** to document the medical necessity of **CRESEMBA**.

[patient's 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, ***[patient's name]*** should receive **CRESEMBA** for the following reasons:

- **List reasons**

In summary, **CRESEMBA** is medically necessary and reasonable for Mr./Ms. ***[Patient's last name]***'s medical condition. Enclosed are copies of ***[patient's name]***'s medical records documenting his/her related symptoms and medical necessity. Please approve using **CRESEMBA** on ***[patient's name]***'s behalf as recommended. If I can provide any additional information, please contact me at ***[insert phone number]*** to ensure the prompt approval of this course of treatment.

Regards,
[Physician Name]

Encl.

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