SAMPLE Letter of Medical Necessity
For XTANDI® (enzalutamide) capsules

Date

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

Attn: Payer Representative
Department Name (optional)

Re: Coverage of **XTANDI (enzalutamide) capsules**
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 **XTANDI.**

The full prescribing information for **XTANDI** can be accessed at www.XTANDI.com.

[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 **XTANDI** for the following reasons:

- ***List reasons***

In summary, **XTANDI** is medically necessary and reasonable for Mr. ***[patient's last name]***'s medical condition. Enclosed are copies of ***[patient's name]***'s medical records documenting his related symptoms and medical necessity. Please approve using **XTANDI** 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]