Sample Format Letter of Medical Necessity

[Insert physician letterhead]

[Medical Director]
[Insurance Company]
[Address]
[City, State, ZIP]

RE: Patient Name _____
Policy Number _____
Claim Number _____

Dear:
I am writing to provide additional information to support my claim for the treatment of **[insert patient name]** with REMICADE® (infliximab) for **[insert diagnosis]**. In brief, treatment of **[insert patient name]** with REMICADE® is medically appropriate and necessary and should be a covered and reimbursed service. Below, this letter outlines **[insert patient name]**'s medical history, prognoses, and treatment rationale.

Summary of Patient's History [You may want to include]:

[Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

- **Patient's diagnosis, condition, and history**
- **Previous therapies the patient has undergone for the symptoms associated with their condition**
- **Patient's response to these therapies**
- **Brief description of the patient's recent symptoms and conditions**
- **Summary of your professional opinion of the patient's likely prognoses without treatment with REMICADE®**

Rationale for Treatment

Given the patient's history, condition, and the published data supporting use of REMICADE®, I believe treatment of **[insert patient name]** with REMICADE® is warranted, appropriate and medically necessary. The accompanying package insert provides the approved clinical information for REMICADE®.

Please call my office at **[insert telephone number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Insert Doctor Name and
Participating provider number]

Enclosures