SAMPLE LETTER OF MEDICAL NECESSITY

[Date]
[Payer Name]
[Payer Address]
Attn: **[Medical Director]**

RE: **[Patient Name]**
[Policy Number]
[Claim Number (if applicable)]

Dear **[Medical Director]**:

I am writing to provide additional information to support my claim for the treatment of **[Patient Name]** with RETACRIT™ (epoetin alfa-epbx) injection **[strength]**. Please see the enclosed documentation that supports the use of this therapy, which was approved by the FDA on May 15, 2018.

I believe treatment of **[Patient Name]** with RETACRIT is medically appropriate and necessary, and it should be a covered and reimbursed treatment.

[Provide a description of patient's relevant medical history based on your clinical judgment such as:]

- **[(He/She)] was diagnosed with [indication] on (insert date)].**
- **[Patient diagnosis, ICD-10-CM, lab results and dates, recent symptoms/condition and history]**
- **[Prior treatments that have been tried, and patient's response to these treatments]**

It is my professional opinion that treatment of **[Patient Name]** with RETACRIT is medically appropriate and necessary for the following reasons:

- **List out reasons**

Please call my office at **[Telephone Number]** if you require any additional information or documentation. I look forward to your timely response.

Sincerely,

[Physician Name]
[Address]
[Telephone Number]

Enclosures **[to be determined by physician]**

[This document is provided as a sample template that may be used to support medical necessity. The physician is responsible for the content of the letter that is customized to include information concerning an individual patient.]

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