SAMPLE:
This letter is only intended as a TEMPLATE Letter of Medical Necessity
INSTRUCTIONS: MUST BE ON HCP'S LETTERHEAD AND MUST BE COMPLETED AND SUBMITTED BY THE HCP.

[OFFICE LETTERHEAD INCLUDING PROVIDER NAME AND ADDRESS]

<Date>
ATTENTION: <Medical Director Name and/or Medical Review/Appeals>
<Payer/Health Plan Name>
<Payer Address>
REGARDING: Medical necessity for <Product Name>
PATIENT NAME: <Patient Name>
DATE OF BIRTH: <Patient Date of Birth>
POLICY ID NUMBER: <Policy ID Number>
PROVIDER ID NUMBER: <Provider ID Number>

Dear <Medical Director Name and/or Medical Review/Appeals>:

I am writing to request authorization for <Product Name> for my patient, <Patient Name>. I have prescribed <Product Name> because this patient has been diagnosed with <diagnosis>, and I believe that therapy with <Product Name> is appropriate for this patient. Attached to this request are <clinical notes regarding this patient's disease state, the FDA approval letter for <Product Name>, and the <Product Name> package insert>.

In my professional opinion, <Product Name> is indicated for <indication from prescribing information>. <Rationale for treating the patient with <Product Name>.>

Best regards,
<Physician Signature>
<Physician Name>

This sample letter is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical or other advice. Use of this template or the information in this template does not guarantee reimbursement for coverage. Coverage and reimbursement may vary significantly by payer plan, patient, and other factors. The information provided is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional. Responsibility for ensuring the accuracy of information included in any communication between the healthcare provider and the payer remains solely with the healthcare provider.

© 2023 Gilead Sciences, Inc. All rights reserved.
US-ADMP-0302 02/23