***Cover Letter for Sample Letter of Medical Necessity***

***for a Nonpreferred Site of Care***

**The following pages may be customized to use as a letter of medical necessity to treat a**

**patient with multiple sclerosis at a nonpreferred site of care.**

The following sample letter is intended to be used as a guide; therefore it is important to tailor the letter to the specific needs of your patients and address the reason(s) why the desired site of care is the appropriate option. You should always include pertinent information about your patient that supports your request.

Please see below for considerations when writing a letter of medical necessity:

* Review the health plan’s preferred site(s) of care and state the reason(s) why the desired site of care is appropriate. Also include any information about your patient to explain why the preferred site(s) of care are not appropriate
* Provide background on your patient’s condition and clearly state your patient’s individual circumstances to justify why the desired site of care is the appropriate choice
* Submit the letter as required by the health plan and state guidelines. It is important that you understand the process for each health plan, including how to submit the request (fax, phone, email, the company’s website, etc.) as well as how and when the decision will be communicated
* Track the status of your request and follow-up with the health plan as needed

[Insert Date]

Request for patient to [Continue Receiving Infusions OR Receive Infusions] at [Insert Name of Site of Care]

RE: [Patient Name]

[Patient Insurance ID Number]

[Patient Date of Birth]

Dear [Health Plan Contact Name]:

I am writing this letter of medical necessity in support of my request to [treat/continue treating] [Patient Name] at [Name of Site of Care] with [Drug Name (generic)].

As a board-certified [field of certification] with [XX] years of experience treating multiple sclerosis (MS), I believe that the site[s] of care preferred by your coverage policy [is/are] not appropriate for my patient’s MS. [Patient Name] has been receiving [Insert Product Name] at [Insert Name of Site of Care] for [XX month(s)/year(s)]. [Patient Name] is treated at this site approximately every month. The staff is very familiar with [his/her/their] health status and treatment plan. I do not want my patient to have any disruption in this continuity of care.

I am requesting for my patient to be treated at [Name of Site of Care] because I have concluded that it is the most appropriate location for the following reason[s]:

* [Include information related to this patient’s history that supports them starting treatment or continuing treatment at the desired site of care. Please see below some reasons to support your request to treat your patient at the desired site of care]
	+ [List details about the patient's logistical ability to travel to the infusion site (e.g. distance or transportation)]
	+ [List details about patient considerations, such as physical and cognitive limitations, familiarity and comfort between patient site and patient, and/or potential disruption to multiple sclerosis treatment plan]
* [Additional information the patient has communicated to you or your staff about why this site of care is preferred]

In summary, based on my patient’s current condition and the information available to date, treating [Patient Name] at [Name of Site of Care] is medically appropriate and necessary.

Please feel free to contact me if you require further information regarding this request. I look forward to your response as soon as possible.

Sincerely,

Prescriber Name]

[Prescriber Specialty]

[Prescriber Contact Info]