SAMPLE LETTER OF MEDICAL NECESSITY

Payers may require prior authorization or supporting documentation in order to process and cover a claim for the requested therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific letter of medical necessity will help to explain the physician's rationale and clinical decision making in choosing a therapy. The following is a sample letter of medical necessity that can be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.*

***NOTE: This sample letter and related information are provided for informational purposes only. It is the responsibility of the HCP and/or their office staff, as appropriate, to determine the correct diagnosis, treatment protocol, and content of all such letters and related forms for each individual patient. Bausch + Lomb does not guarantee coverage or reimbursement for the product.**

[Date]
[Contact Name of medical director or other payer representative]
[Name of Health Insurance Company]
[Address]
[City, State, Zip]

Re: Letter of Medical Necessity for [Insert Product(s)]

Patient: [Patient Name] Group/policy Number: [Number] Date(s) of service: [Dates]
Diagnosis: [Code(s) & Description(s)]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to [REQUEST PRIOR AUTHORZATION/DOCUMENT MEDICAL NECESSITY] for treatment with [INSERT PRODUCT]. The [PATIENT NAME] has a diagnosis of [DIAGNOSIS] and needs treatment with [INSERT PRODUCT], and that [INSERT PRODUCT] is medically necessary for [him/her] as prescribed. On behalf of the patient, I am requesting approval for use and subsequent payment for the [TREATMENT].

Patient Medical History and Diagnosis
[PATIENT NAME] is a [AGE]-year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [LIST OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for [TREATMENT] as described below.

[INSERT ALL RELEVANT MEDICALLY NECESSARY CLINICAL DETERMINATIONS]

Based on the above clinical details, I am confident you will agree that [INSERT PRODUCT] is medically necessary as part of the overall treatment planning for this patient.

Please consider coverage of [INSERT PRODUCT] for [PATIENT NAME] and approve use and subsequent payment for [INSERT PRODUCT] as detailed above. Please refer to the enclosed Prescribing Information for [INSERT PRODUCT]. If you have any further questions, please do not hesitate to call me at [PHYSICIAN TELEPHONE NUMBER]. Thank you for your prompt attention to this matter.

Sincerely,
[PHYSICIAN NAME], [DEGREE INITIALS]
[PROVIDER IDENTIFICATION NUMBER]

Enclosures:
(Attach as appropriate) Prescribing Information (PI), Clinic notes and labs, Supporting clinical study information

CC: [Medical Director, patient, other parties as appropriate]

The information contained in this template letter is provided by Bausch + Lomb for patients who have been prescribed a Bausch + Lomb medication. There is no requirement that any patient or healthcare provider use any Bausch + Lomb product in exchange for this information, and this template is not meant to substitute for a prescriber's independent medical decision-making

.

VID.0029.USA.20