Sample Letter of Medical Necessity

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when providing a letter of medical necessity to a patient's insurance company. Use of this template or the information in this template does not guarantee coverage. It is not intended to be a substitute for, or to influence the independent clinical decision of, the prescribing healthcare professional.

[Date]
[Insurance Company Contact]
[Insurance Company Name]
[Insurance Company Address]
[Insurance Company City, State Zip]

Re:
Patient: [Patient's First and Last Name]
Subscriber ID #: [Insurance Subscriber ID]
Subscriber Group #: [Insurance Group ID]
Date of Birth: [Patient's Date of Birth]

Dear [Insurance Company Contact]:

I am writing on behalf of my patient, [Patient's First and Last Name], to demonstrate the medical necessity and support for the coverage of VYEPTI® (eptinezumab-jjmr) for [Indication and ICD-10 code].

I have read and acknowledge your policy for the responsible management of drugs in this category. In this letter, I provide my rationale for the use of VYEPTI by [Patient's First and Last Name]. I have also included a brief description of the patient's medical history, including prior therapies, and [his/her] current condition and diagnosis.

[Provide details on the patient's diagnosis, current condition, symptoms, treatment history, and support for approval, including the following:

- Records indicating the patient's diagnosis and the date of diagnosis
- Rationale for treatment
- Brief description of the patient's disease state
- Comprehensive list of any prior treatments and response to those treatments
- Rationale for selecting VYEPTI
- Additional clinical support for the appeal
- Additional medical documentation or studies that support your argument for approval]

Based on the above information, I hope that you will agree that VYEPTI is medically necessary for this patient.

Please contact my office by calling [Practice Phone Number] for any additional information you may require in support of coverage for VYEPTI. I look forward to your timely approval.

Please see Important Safety Information below.

Sincerely,

[Physician's Signature]
[Physician's Name]
[Provider Identification Number]

[Patient's Signature]
[Patient's Name]

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EPT-B-100510

[Name of Practice]
[Phone Number]

Enclosures: (attach as appropriate)
• VYEPTI Prescribing Information
• Patient clinical/diagnostic notes and relevant lab reports

Indication

VYEPTI® is indicated for the preventive treatment of migraine in adults.

Important Safety Information

CONTRAINDICATIONS

- VYEPTI is contraindicated in patients with serious hypersensitivity to eptinezumab-jjmr or to any of the excipients. Reactions have included angioedema.

WARNINGS AND PRECAUTIONS

- **Hypersensitivity reactions:** Hypersensitivity reactions, including angioedema, urticaria, facial flushing, and rash, have occurred with VYEPTI in clinical trials. Most hypersensitivity reactions occurred during infusion and were not serious, but often led to discontinuation or required treatment. Serious hypersensitivity reactions may occur. If a hypersensitivity reaction occurs, consider discontinuing VYEPTI, and institute appropriate therapy.

ADVERSE REACTIONS

- The most common adverse reactions (≥2% and at least 2% or greater than placebo) in the clinical trials for the preventive treatment of migraine were nasopharyngitis and hypersensitivity.

[For more information, please click on Prescribing Information including Patient Information.]

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