Sample Letter of Medical Necessity
Please transcribe this sample letter on to your own physician's letterhead before printing. This letter is intended to be accompanied with the Medical Necessity Form.

[Date]

[Prescriber Name]
[Your Address]
[Your City, State, ZIP]
[Your phone number]

[Name of Rx Plan]
[Address of Rx Plan]

Re: Authorization for PANCREAZE® (pancrelipase) Delayed-Release Capsules use for [Patient's name]
Member ID:
Group #:
Rx Bin#:
Date of Birth:

To Whom It May Concern:

I am writing to document the medical necessity of PANCREAZE® (pancrelipase) Delayed-Release Capsules for my patient, [patient's name]. The enclosed documentation provides information about the patient's medical history, diagnosis, and my treatment rationale.

PANCREAZE is indicated for the treatment of exocrine pancreatic insufficiency in adult and pediatric patients. [Patient's name] was originally diagnosed with [disease(s)] in [year(s) of diagnosis(es)]. [Include a description of investigation leading to diagnosis(es) and any treatments that have never worked or stopped working and those to which patient response was inadequate.]

I plan to treat [patient name] with PANCREAZE. [Include statement about why PANCREAZE is right for the patient].

In my professional opinion, PANCREAZE is medically necessary and is the appropriate treatment choice for my patient at this time. Thus, I recommend PANCREAZE qualify for reimbursement for my patient. Please feel free to contact me if you require additional information.

Sincerely,
Physician Name, MD and Signature

CC: [Patient's name]

Ref: PANCREAZE Full Prescribing Information. Campbell, CA: VIVUS LLC; 2024.

Medical Necessity Form

Medication* _____ ☐ New Therapy ☐ Continuing Therapy

Dose* _____

Patient Information

Last Name:* _____ First Name:* _____ Birth Date:* _____ Gender:* ☐ Male ☐ Female

Street:* _____ City:* _____ State:* _____ ZIP:* _____

Home Phone:* (____) _____ Work/cell phone:* (____) _____

Insurance No.:* _____ Policy/group No.: _____

Policyholder Name:* _____ Policyholder birth date*: _____

Medical Necessity Information

ICD-10 CODES - Diagnoses & Related co-morbidities (Check all that apply):

☐ **K86.81** Exocrine pancreatic insufficiency	☐ **K86.89** Other specified diseases of pancreas	☐ **K86.9** Disease of pancreas, unspecified
☐ **K85.0** Idiopathic acute pancreatitis	☐ **K85.1** Biliary acute pancreatitis	☐ **K85.2** Alcohol induced acute pancreatitis
☐ **K85.3** Drug induced acute pancreatitis	☐ **K85.8** Other acute pancreatitis	☐ **K85.9** Acute pancreatitis, unspecified
☐ **K86.0** Alcohol-induced chronic pancreatitis	☐ **K86.1** Other chronic pancreatitis	☐ **Other** Specify by ICD-10 CM _____
☐ **Other** Specify by ICD-10 CM _____	☐ **Other** Specify by ICD-10 CM _____	☐ **Other** Specify by ICD-10 CM _____

Adjunct Therapies & Duration (Check all that apply):

☐ Nutritionist ____months	☐ MD-directed program ____months	☐ Other: _____
☐ Other: _____	☐ Other: _____	☐ Other: _____

Prescriber's last name:* _____ First name:* _____

Practice name: _____ Specialty: _____

Street:* _____ City:* _____ State:* _____ ZIP:* _____

Phone:* (____) _____ Fax:* (____) _____

Prescriber NPI†: _____ Group NPI: _____

State license #*: _____

By signing below, I certify that the above therapy is medically reasonable and necessary.

Prescriber's Signature* _____ Date* _____

*Required field †National Provider Identifier