Sample Letter of Medical Necessity
Please translate 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 due to cystic fibrosis or other conditions. [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; 2021.

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