Sample Letter of Medical Necessity

(Practice Letterhead)

(Date)

(Payer Name)
(Payer Representative)
(Payer Address)
(City, State ZIP Code)
(Payer Fax Number)

Attention: **(Payer Representative)**
Attention: **(Department Name)**

Re: Coverage of **BLINCYTO® (blinatumomab)**
Subscriber: **(Subscriber's First and Last Name)**
Patient Name: **(Patient's First and Last Name)**
Policy # / Patient ID: **(Policy Number / Patient's ID)**
Group #: **(Group Number)**
Patient Date of Birth: **(Patient Date of Birth)**
Patient Age: **(Patient Age)**
Patient Sex: **(Patient Sex)**

Dear Medical or Pharmacy Director:

I am writing on behalf of **(Patient's name)**, **(policy #)**, to document the medical necessity of **BLINCYTO®.**

(Mr/Mrs/Ms) (Patient's name) was provided with **BLINCYTO®**. Please see full Prescribing Information, including **Boxed WARNINGS** and Medication Guide, for **BLINCYTO®** at https://www.pi.amgen.com/~/media/amgen/repositorysites/pi-amgen-com/blincyto/blincyto_pi_hcp_english.pdf.

(Mr/Mrs/Ms) (Patient's name)'s medical history and course of treatment are as follows:

(Describe the patient's history, diagnosis, and previous and current treatment regimens and their outcomes. NOTE: Physicians should exercise medical judgment and discretion in regard to making an appropriate diagnosis and characterization of an individual patient's medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.)

In my clinical opinion, **(Mr/Mrs/Ms) (Patient's name)** should receive **BLINCYTO®** for the following reasons:

- **(List reasons)**

In summary, **BLINCYTO®** is medically necessary and reasonable for **(Mr/Mrs/Ms) (Patient's name)'s** medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,

(Physician's name)