**Sample Letter of Medical Benefit Coverage Request**

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| **[Insurance Company]****[Address]****[City, State, Zip]** | Re: **[Patient Name]****[Policy #]****[DOB]****[Address]****[City, State, Zip]** |
| To Whom It May Concern: I am writing on behalf of my patient, **[Patient Name, ID and Group Number]** to request a determination of coverage approval of **[Product name (generic name)] [SOMATULINE® DEPOT (lanreotide)], [DYSPORT® (abobotulinumtoxinA)], [ONIVYDE® (irinotecan liposome injection)], [INCRELEX® (mecasermin)]** associated with **[ICD 10 Code]** under medical benefits coverage. The patient has been notified that there is no coverage for the product.**Patient’s History, Past Treatments and Drugs Utilized (1500-character limit):** **[Include information outlining when the patient was diagnosed and severity of symptoms. Provide patient response to past treatments]**.**Treatment Rationale (1500-character limit):** **[Provide information on patient response to past treatments and anticipated prognosis and rationale for the currently prescribed product]**. **Supporting Study Data (1500-character limit):****[Include references to published medical study data evaluating the use of the currently prescribed product. Remember to include the FDA approved indications and usage]**.The ordering physician is **[Physician Name, NPI #]**.The coverage determination decision may be faxed to **[Fax #]** or mailed to **[Physician Business Office Address]**. Please also send a copy of coverage determination decision to the patient. Sincerely, **[Physician Name and Signature]****[Phone #]****Enclosure: [Pharmacy coverage determination denial]**©2022 Ipsen Biopharmaceuticals, Inc. April 2022 MP-US-000428 V2.0 |