SAMPLE Letter of Medical Necessity

<Physician Letterhead>

Date: <Current Date>
Address: <Address of Insurance Company>
Re: <Patient Name>, medical necessity for treating with FIRAZYR
Date of birth: <Patient Date of Birth>
Member ID: <Patient ID Number>
Group number: <Patient Group Number>

To <Whom It May Concern>:

I am writing on behalf of my patient, <Patient Name>, to document the medical necessity of FIRAZYR® (icatibant injection) for the treatment of hereditary angioedema (HAE). FIRAZYR is indicated for the treatment of acute attacks of HAE in adults 18 years of age and older. The treatment of <Patient Name> with FIRAZYR is medically necessary and supported by the following information.

Patient medical history and diagnosis:
<Include information on patient's diagnosis, current medical condition, previous and current treatments, and any other relevant information>

Treatment rationale:
I have selected treatment with FIRAZYR for my patient based on available clinical data and believe it is the appropriate treatment choice. Given the history and medical needs of <Patient Name>, I believe that acute treatment with FIRAZYR is warranted and medically necessary.

If you have any further questions or if any additional information is required, please contact my office at <XXX-XXX-XXXX>. Thank you for your attention to this matter and I look forward to receiving your response.

Sincerely,

<Physician's Name>
<Physician's ID Number>

<Enclosures:>
<Prescribing Information for FIRAZYR>
<Patient medical records>
<Other relevant materials and supporting documents>

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