

# Sample Non-Formulary Letter of Medical Necessity

## [Physician Letterhead]

[Date]  
[Insurance Company Name]  
Insured: [Patient Name]  
Policy Number: [Patient's Insurance ID Number]

To whom it may concern,

I am writing on behalf of my patient, [Patient Name], to request that you approve coverage for [PRODUCT] as a medically necessary treatment for [Patient Name]'s [Patient's diagnosis, date of diagnosis]. This letter provides information about my patient's medical history, diagnosis, and details regarding the medical necessity of the requested treatment with [PRODUCT].

### Summary of Patient's History

[Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

You may want to include:

- [Patient's history, diagnosis, and current condition]
- [Patient's previous treatments/and response to treatment]
- [Summary of your professional opinion of the patient's prognosis or disease progression without treatment with PRODUCT]

### Rationale for Treatment

Given the patient's medical history and current clinical status, [Patient Name] is appropriate for the approved indication for [PRODUCT], and I believe treatment with [PRODUCT] is warranted, appropriate, and medically necessary. The accompanying package insert provides the approved clinical information for [PRODUCT].

If you have further questions, please contact my office at [physician's primary phone.]

Sincerely,  
[Insert physician name and participating provider number]

Enclosures

**Note to healthcare provider or staff:** Review the insurer's website or contact their customer service for specific forms that may need to be completed and included for requesting a formulary exception.

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