Sample Letter of Medical Necessity—SYNAGIS® (palivizumab)

[The following is a sample Letter of Medical Necessity. The text within pink brackets is templated and should be replaced with pertinent information for the individual patient on whose behalf you are submitting the letter. Italicized information within brackets is intended to provide additional guidance and should be omitted from the final letter.]

[Date]
[Payer Medical Director/Contact Name]
[Payer Organization Name]
[Payer Street Address]
[Payer City, State, ZIP Code]

RE: [Patient Name]
Date of birth: [Patient's Date of Birth]
Policy ID/Group number: [Policy ID/Group Number]
Policy holder: [Policy Holder's Name]

Dear [Payer Medical Director/Contact Name]:

I am [Physician Name, credentials, specialty, hospital/practice], and I am writing on behalf of my patient, [Patient Name], to document the medical necessity of SYNAGIS® (palivizumab), which is prescribed as prophylaxis for respiratory syncytial virus (RSV).

1. Patient-Specific Rationale for Treatment
In brief, it is my medical opinion that [initiating/continuing] treatment with SYNAGIS for [Patient Name] is medically appropriate and necessary, and its administration should be covered. Outlined below are [Patient Name]'s medical history and prognosis, and the rationale for treatment with SYNAGIS. The patient meets the following criteria for treatment: [List specific criteria here].

[Note: The following section is to be completed by the physician based on the patient's medical history and prognosis.]

2. Summary of Patient's Medical History *[You may be required to include]*

- [Patient's diagnosis and current condition]
- [Relevant medical history]
- [Neonatal intensive care unit clinical notes]

3. SYNAGIS Dosing Information

[Note: Mention the starting dose and potential duration of therapy based on SYNAGIS dosing and administration. You may choose to include details from the Prescribing Information attached to the end of this sample letter and/or mention the current RSV trends and American Academy of Pediatrics Interim Guidance.]

Please call my office at [telephone number] if you require additional information. I look forward to receiving your timely response and approval of this authorization.

Sincerely,
[Physician Name]
[Title, Institution]
[Email/Phone Number]

[Note: Attach full Prescribing Information.]