Sample Letter of Medical Necesssity

{Date Created}

{Provider Full Name}
{Provider_Address1}
{Provider_Address2}
{Provider_City}, {Provider_State} {Provider_ZIP}
Fax: {Provider_Fax}

RE: Patient Name: {Patient_Full Name}
Patient Case #: {Patient_Case_ID}idkfl

Dear {Provider Name},

The sample Letter of Medical Necessity to follow is being provided in response to your unsolicited request for assistance obtaining a Prior Authorization (PA) or to otherwise facilitate the processing of an insurance claim. It is only a guide and must be tailored appropriately based on each individual patient's condition and circumstances.

Once completed, the letter section of this document should be printed on office letterhead and submitted directly to the payer.

If you have any additional questions please contact the APOKYN® Patient Program. A team member is here to assist you from 8:00 AM to 8:00 PM Eastern Time, Monday through Friday.

Sincerely,

Case Manager
{Program Name}
Phone: {Program Phone}
Fax: {Program Fax}
Email: {Program Email}

Please see Important Safety Information for APOKYN and full Prescribing Information and Patient Instructions for Use/Patient Information at APOKYN.com.

SAMPLE ONLY

[Provider Name (on office letterhead)]
[Provider Address]

[Date]

[Name of Medical Director]
[Title]
[Name of Insurer]
[Address of Insurer]
[City, State, ZIP Code]

Re: [Patient's Name] [Patient's ID umber]

Dear [Name of Medical Director]:

I am writing to provide you with information regarding the medical necessity of treating my patient, [patient's name], with APOKYN® (apomorphine hydrochloride injection) for [indicate diagnosis]. [Patient's name] has been/is being treated with [name the treatments] for this condition. [Patient's name] medical history is as follows:

Medical History Summary: [Insert patient's medical history below]

1. APOKYN was prescribed for [patient's name] because [state medical reasons for using APOKYN (e.g., for relief of Parkinson's disease symptoms during acute, intermittent treatment of "OFF" episodes associated with advanced Parkinson's disease)].
2. Refer to your years of professional clinical practice and, if applicable, your past experience with APOKYN in similar patient types.
3. Include other provider's name, if known, if patient was referred to you for more intensive management of his/hercondition.

[Patient's name] will be treated with APOKYN [identify the planned course of treatment and duration]. The clinical expectations of treatment with APOKYN include [indicate expectations and basis for anticipated outcome]. There is no therapeutic alternative for APOKYN.

APOKYN is used by injection, as needed, to treat symptoms of Parkinson's disease (PD). APOKYN is indicated for the acute, intermittent treatment of hypomobility, "OFF" episodes ("end-of-dose wearing-off" and unpredictable "on-off" episodes) in patients with advanced Parkinson's disease. An "OFF" episode may include symptoms such as muscle rigidity, tremors, hypomobility, slow movements, and difficulty starting movements. This is appropriate for [patient's name] because [state how this will help patient].

In summary, APOKYN is being prescribed for [patient's name] because [insert your professional experience with APOKYN]. The clinical expectation of treatment with APOKYN is to relieve the [insert patient symptom(s)] that has/have not responded to other modalities.

I hope this information is helpful to you in understanding why I have pursued treatment with APOKYN. If you require any additional information, please contact me at [insert your phone number].

Sincerely, [Physician's Name]
[Physician's contact information]