

Sample Letter of Medical Necessity

Please Note: The following is a template for MYCAPSSA® (octreotide) that your office can customize based on your patient's medical history. These materials are available for download and public personal use. These materials have no monetary value and are not to be re-sold or repurposed. They are solely for your personal use. No purchase from or relationship with Chiesi is required to download or use these materials. Chiesi makes no representations or warranties about these materials or their fitness for any specific use. Chiesi is not responsible for any changes made to these template documents. It is the sole responsibility of the health care provider to include the proper information and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient. All billing and coding decisions are the responsibility of the relevant physician. Chiesi makes no guarantee regarding coverage or reimbursement.

Using this template:

- Fill in the template using the instructions highlighted in magenta.
- Once you have filled in the information, remove any remaining instructions in magenta.
- Select all the text and change the font to black so the whole document appears as one letter.

Use the steps above as a checklist to make sure you have completed these steps prior to sending. **It is important to follow these steps to ensure the letter is clear and concise.**

Attention:
[Contact name]
[Insurance company name]
[Insurance company street address]
[Insurance company city, state ZIP]

Re: [Insured patient name]
Date of birth: [Patient date of birth]
Policy number: [Policy 4*]
Group number: [Group 4*]

Subject: Intent to treat with MYCAPSSA® (octreotide) delayed-release oral capsules

To Whom It May Concern:

I am writing this letter of medical necessity on behalf of my patient [Patient Name, ID#, Group #] to request approval for MYCAPSSA® (octreotide). Included in this letter of medical necessity is information on the treatment rationale, medical records, medical necessity data and medical studies confirming currently prescribed product as an effective treatment for the diagnosis associated with E22.0.

Treatment Rationale:

Based on my clinical judgment, MYCAPSSA is medically necessary for [Patient name] because [Provide information on patient response and history to past treatments and anticipated prognosis and rationale for the currently prescribed product].

Outline of Medical Studies:

MYCAPSSA is an FDA-approved oral somatostatin analog indicated for long term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide. [Consider inserting a summary of evidence, such as clinical study results, demonstrating outcomes in the condition and/or patient population].

Medical Record Information:

[Patient Name] is a [age]-year-old [male/female] diagnosed with acromegaly and has been in my care since [year]. My current treatment plan for [patient name] includes [current treatment(s) and dosage]. [Patient name] has been on this treatment plan since [start date of current treatment plan]. Previous treatments for [patient name] include [prior treatment(s) and reason(s) for discontinuation].

Please promptly review the information provided in order to authorize treatment and approve [Patient Name]'s coverage for MYCAPSSA. My office can be contacted at [Physician phone number] or [Physician email address] if additional information is required to approve this request.

Sincerely,

[Physician Name and Signature]
[Phone Number]

Enclosures:

- [MYCAPSSA Prescribing Information]
- [MYCAPSSA FDA Approval Letter]
- [Relevant medical records such as previous approvals of MYCAPSSA by the health plan, patient's dose of MYCAPSSA, or patient's response to and tolerance of MYCAPSSA]

Reference: MYCAPSSA [package insert]. Chiesi USA, Inc. 2024.