**Sample Letter of Medical Benefit Coverage Request**

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| **[Insurance Company]**  **[Address]**  **[City, State, Zip]** | Re: **[Patient Name]**  **[Policy #]**  **[DOB]**  **[Address]**  **[City, State, Zip]** |
| To Whom It May Concern:  I am writing on behalf of my patient, **[Patient Name, ID and Group Number]** to request a determination of coverage approval of **[Product name (generic name)] [SOMATULINE® DEPOT (lanreotide)], [DYSPORT® (abobotulinumtoxinA)], [ONIVYDE® (irinotecan liposome injection)], [INCRELEX® (mecasermin)]** associated with **[ICD 10 Code]** under medical benefits coverage. The patient has been notified that there is no coverage for the product.  **Patient’s History, Past Treatments and Drugs Utilized (1500-character limit):**  **[Include information outlining when the patient was diagnosed and severity of symptoms. Provide patient response to past treatments]**.  **Treatment Rationale (1500-character limit):**  **[Provide information on patient response to past treatments and anticipated prognosis and rationale for the currently prescribed product]**.  **Supporting Study Data (1500-character limit):**  **[Include references to published medical study data evaluating the use of the currently prescribed product. Remember to include the FDA approved indications and usage]**.  The ordering physician is **[Physician Name, NPI #]**.The coverage determination decision may be faxed to **[Fax #]** or mailed to **[Physician Business Office Address]**. Please also send a copy of coverage determination decision to the patient.  Sincerely,  **[Physician Name and Signature]**  **[Phone #]**  **Enclosure: [Pharmacy coverage determination denial]**  ©2022 Ipsen Biopharmaceuticals, Inc. April 2022 MP-US-000428 V2.0 | |