

**Checklist for Letter of Medical Necessity**

Payers vary in their medical necessity requirements. The sample Letter of Medical Necessity on the following page may be a helpful tool for you and your office to utilize when a Letter of Medical Necessity is needed. Providers should consider including in any such Letter of Medical Necessity the following types of information:

* Patient Name
* Patient’s Policy Number
* Patient’s medical history, diagnosis, and current condition
* If previous treatment given, list drug(s), dosage(s), schedule(s), clinical response(s), and reason(s) for discontinuation
* A summary of the provider’s clinical assessment and rationale for requesting coverage

This checklist and the following sample letter are for informational purposes only. It is not a substitute for a provider’s independent professional judgment and is not intended as legal, medical, or clinical advice. This is also not a guarantee of coverage or of reimbursement. Healthcare providers should always confirm coverage requirements for individual patients with their respective insurance providers.

***This page is for reference only. Content of this page does not need to be sent to the insurance company***

**Sample Letter of Medical Necessity for LUMRYZTM (sodium oxybate) for extended-release oral suspension, CIII**

*[Physician Letterhead]*

**[Date]**

To: **[Payer Name]**

**[Payer Street Address]**

**[Payer City, State and Zip]**

Re:Patient Name: **[Name]**

Date of Birth: **[Date of Birth]**

Policy ID Number: **[ID Number]**

Policy Group: **[Group Number]**

To Whom It May Concern:

I am writing to document the medical necessity of LUMRYZTM (sodium oxybate) for extended-release oral suspension, which I have prescribed for my patient, **[Patient Name]** to treat **[Diagnosis/ICD-10 Code]**.

LUMRYZ (sodium oxybate) for extended-release oral suspension is a central nervous system depressant indicated for the treatment of cataplexy or excessive daytime sleepiness (EDS) in adults with narcolepsy. The full Prescribing Information, including BOXED WARNING and Medication Guide for LUMRYZ is available at [www.LUMRYZ.com](http://www.LUMRYZ.com).

* Patient’s medical history, diagnosis, and current condition:

**[Provide a brief statement about the patient’s diagnosis****, examples and dates of previous testing, and medical history, including comorbidities and any health issues that affect the provider’s treatment selection]**

* Patient’s response to prior treatments:

**[Provide a summary of all prior treatments (e.g., name of medication, dose, start/stop dates, length of treatment) and patient’s response to those treatments, including reasons for patient’s discontinuation (e.g., lack of efficacy, inability to tolerate, dosing issues). If applicable, provide reasons for not prescribing another medication for the patient’s condition (e.g., contraindications).]**

In my independent clinical opinion, LUMRYZ is medically necessary for **[Patient Name]**’s medical condition for the following reason(s):

**[Provide a summary as to why, based on the provider’s clinical judgment, the patient requires treatment with LUMRYZ]**

Please contact my office at **[Phone Number]** if additional information is necessary to ensure a prompt response and approval for this course of treatment.

Sincerely,

**[Prescriber Signature]**

**[Prescriber Name]**

Enclosure(s):

**[List enclosures as appropriate. Examples of enclosures include: excerpt(s) from patient’s medical records, Prior Authorization form, relevant clinical practice guidelines, product Prescribing Information]**