Sample Letter of Medical Exception

Instructions for Use:

Below is a template for your reference when drafting a Letter of Medical Exception. Please submit your letter on your office letterhead and replace all bracketed information with the patient-specific information.

As a reminder, the information contained in this sample letter is provided for informational purposes only. Providers are responsible for identifying and including any payer-specific requirements to ensure the accuracy and completeness of all information and materials submitted when requesting coverage for an individual patient. Please refer to the full Prescribing Information for FOTIVDA® (tivozanib) when determining whether the therapy is clinically appropriate for your patient.

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Full Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number]
Case ID Number: [Case ID Number (if available)]

To Whom It May Concern,

I understand that the [plan name] policy for [patient name] requires [restriction description] prior to the approval of FOTIVDA® (tivozanib) treatment. However, I believe that [patient name] requires FOTIVDA without [restriction description] due to clinical and medical circumstances. Please see below for details about symptoms, previous treatments, medical history, and treatment rationale that supports the claim for medical exception for [patient name].

Patient's Clinical/Medical History

- [Patient's ICD-10-CM diagnosis code and date of diagnosis]
- [Patient's first visit date and date of referral]
- [Severity of patient's condition]
- [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- [Patient's disease progression]
- [Any additional factors impacting FOTIVDA treatment selection]

Justification for Medical Exception

- [State the clinical rationale for treatment with FOTIVDA]
- [Describe why the plan requirement is not appropriate for your patient]
- [List concerns that may include experience on similar therapies, drug side effects, and any other patient-specific considerations]

Treatment Plan

- [Include plan of treatment: dosage, frequency, and length of treatment]
- [Clinical rationale for the use of FOTIVDA]

Summary

Based on the above, I am certain that you will agree FOTIVDA is an appropriate treatment for [patient name]. A timely approval of FOTIVDA by [plan name] without [restriction description] would be greatly appreciated by both myself and my patient. Please contact me at [phone number] if you need more information to approve a medical exception for [patient name].

Sincerely,

_____

[Physician Name]
[Physician Address]
[Physician Phone]

Enclosures: [Full prescribing information, patient medical history, clinical notes, relevant peer-reviewed articles, clinical practice guidelines, FDA approval letter, etc.]