Sample Letter of Medical Exception

Below is a template for your reference when drafting a Letter of Medical Exception. The information contained in this sample letter is provided for informational purposes only. Providers are responsible for the accuracy and completeness of all information and materials submitted requesting coverage for an individual patient. Please refer to the full Prescribing Information for FOTIVDA® (tivozanib), including Important Safety Information, 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.]