

# SAMPLE LETTER OF MEDICAL NECESSITY

---

[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 am writing on behalf of my patient, (patient name), to provide information supporting medical necessity for MONJUVI® (tafasitamab-cxix) treatment. In this letter, I am providing my patient's medical history, diagnosis, and a summary of their treatment plan. I have also provided a brief description of the patient's previous treatments and a clinically-based treatment rationale supporting the medical necessity for MONJUVI.

## **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]
- ▶ [Patient's performance status]
- ▶ [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- ▶ [Patient's disease progression and scan history]
- ▶ [Any additional factors impacting MONJUVI treatment selection]

## **Treatment Plan**

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

## **Summary**

Based on the provided information, I believe MONJUVI is medically necessary for [Patient name]. Please find the enclosed additional documents [list any attachments] that support my clinical decision. If you need additional information for a timely approval, please contact my office at [insert office phone number].

Sincerely,

[Physician Name]

[Physician Address]

[Physician Phone]

---

**Enclosures:** [List any applicable enclosures such as prescribing information, patient medical history, relevant peer-reviewed articles, FDA approval letter, etc.]