[Insert Date]

Request for patient to [Continue Receiving Infusions OR Receive Infusions] at [Insert Name of Site of Care]

[Optional: Claim rejection number]

RE: [Patient Name], [Patient Insurance ID Number], [Patient Date of Birth]

Dear [Health Plan Contact Name]:

This letter is regarding your site of care policy of [Insert Product Name] for my patient. I feel that [Insert Name of Site of Care] is the most appropriate location for [Patient Name] to receive [his/her] [Insert Product Name] treatment.

[Patient Name] has been receiving [Insert Product Name] at [Insert Name of Site of Care] for [XX] years. [Patient Name] is treated at this site approximately every month. The staff is very familiar with [his/her] health status and treatment plan. I do not want my patient to have any disruption in this continuity of care.

I would like my patient to remain at their current site of care for the following reason(s):

[Include any additional information related to this patient's history that supports them continuing treatment at the current site of care, for example:

- List details about the patient's logistical ability to travel to the infusion site, for example, distance or transportation
- List details about patient considerations such as:
    - Physical and cognitive limitations
    - Familiarity and comfort between patient site and patient
    - Potential disruption to multiple sclerosis treatment plan
- Any information the patient has communicated to the HCP about why this site of care is preferred]

In the case that this application for [Patient Name] to remain at [Insert Name of Site of Care] for treatment is denied, I am also requesting a peer-to-peer discussion with a plan medical director. Please feel free to contact me if you require further information regarding this request. I look forward to your response as soon as possible.

Sincerely,
[Name]