

## ***Sample Letter of Medical Necessity for a Nonpreferred Site of Care***

**Note: the sample letter below is for your reference only and is intended to be customized for individual patients with relapsing multiple sclerosis (RMS) at a nonpreferred site of care based upon your independent clinical evaluation and medical judgment.**

[Insert Date]

[ATTN: Health Plan Contact Name]  
[Health Plan Name]  
[Address]

[Patient Name]  
[Patient Insurance ID Number]  
[Patient Date of Birth]  
[Reference Number]

**RE: Request for My Patient to [Continue Receiving Infusions/Receive Infusions] at [Insert Name of Site of Care]**

Dear [Health Plan Contact Name]:

I am writing this letter of medical necessity in support of my request to [treat/continue treating] [Patient Name] at [Name of Site of Care] with [drug name (generic)].

As a [board-certified (insert field of certification)] [working in consultation with a specialist in the field of neurology/multiple sclerosis (MS)] with [XX] years of experience treating MS, I believe that the site[s] of care preferred by your coverage policy [is/are] not appropriate for my patient. [Patient Name] has been receiving [Drug Name] monthly at [Insert Name of Site of Care] for [XX month(s)/year(s)].

I am requesting for my patient to be treated at [Name of Site of Care] because I have concluded that it is the most appropriate location for the following reason[s]:

- [HCP to insert reasons for their patient starting/continuing treatment at the desired site of care. Examples include:
  - Patient's logistical ability to travel to the infusion site (eg, distance or transportation)
  - Changing sites can introduce delays, unfamiliar processes, and gaps in risk mitigation, factors that could compromise both treatment efficacy and patient safety
  - Patient has physical and cognitive limitations
  - Familiarity and comfort between site of care staff and patient, and/or potential disruption to MS treatment plan
  - (If health plan is requiring home infusion) Patient cannot accommodate the space and consistency needed for home infusion]
- [Additional information the patient has communicated to you/your staff about why this site of care is preferred]

In summary, based on my patient's current condition and the information available to date, treating [Patient Name] at [Name of Site of Care] is medically appropriate and necessary.

Please feel free to contact me if you require further information regarding this request. I look forward to your response.

Sincerely,

[Prescriber Signature]