



Celgene Patient Support®

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LETTER OF MEDICAL NECESSITY TEMPLATE

A Letter of Medical Necessity is required by the insurance plan as a part of an appeal submission. **Please submit this letter on office letterhead.** Please provide the medical justification for this treatment choice and a brief health history, including all previous treatments. Below is a sample template that can be referenced when writing this letter.

[DATE]

[MEDICAL or PRESCRIPTION INSURANCE COMPANY]

[PATIENT NAME]

[PATIENT DOB]

To Whom It May Concern:

[PATIENT NAME] is a patient under my care for **[DIAGNOSIS]** (including ICD-10 code and method of diagnosis [eg, bone biopsy, labs]).

Health History (including review of symptoms and comorbidities):

Previous Treatments (eg, surgery, chemotherapy, previous drug combinations):

Reason for Treatment Choice (does not need to include in-depth scientific data, just brief summary of physician notes):

Sincerely,

[PHYSICIAN NAME (please make sure to sign)]

[DATE]

Confidentiality Note: This message is strictly confidential. It is intended only for the use of the addressee(s) named above. Dissemination, distribution, copying or use of this message, other than by such addressee(s), is strictly prohibited. If you have received this message in error, please immediately notify us by telephone at 1-800-931-8691 and return the original to us at the address above.

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