CELGENE PATIENT SUPPORT®

Celgene Patient Support®
86 Morris Avenue
Summit, NJ 07901

Phone: 1-800-931-8691
Fax: 1-800-822-2496

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]