Sample Letter of Medical Necessity

Payers may require prior authorization or supporting documentation in order to process and reimburse a claim for BENLYSTA (belimumab). A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Letter of Medical Necessity will help to explain the physician's rationale and clinical decision-making in choosing BENLYSTA. The following is a template Letter of Medical Necessity for BENLYSTA. *Please note some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.*

SAMPLE LETTER OF MEDICAL NECESSITY

Payers may require prior authorization or supporting documentation in order to process and cover a claim for BENLYSTA® (belimumab) therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific Letter of Medical Necessity will help to explain the physician's rationale and clinical decision making in choosing BENLYSTA. The following is a template Letter of Medical Necessity for BENLYSTA that can be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.*

[Date]

[Contact Name of medical director or other payer representative]
[Contact Title]
[Name of Health Insurance Company]
[Address]
[City, State, Zip]

Re: Letter of Medical Necessity for [HCPCS Code] [Drug name, billing unit]

Patient: [Patient Name]
Group/policy Number: [Number]
Date(s) of service: [Dates]
Diagnosis: [Code & Description]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [PATIENT NAME], to [REQUEST PRIOR AUTHORZATION/DOCUMENT MEDICAL NECESSITY] for treatment with BENLYSTA® (belimumab). The patient will be treated with BENLYSTA for [DIAGNOSIS]. BENLYSTA is indicated for treatment of [Indication Statement]. This letter serves to document that [PATIENT NAME] needs BENLYSTA and that BENLYSTA is medically necessary for [him/her] as administered. On behalf of the patient, I am requesting approval for use and subsequent payment for the treatments.

Medical History and Diagnosis
[PATIENT NAME] is a [AGE]-year-old [MALE/FEMALE] diagnosed with [DIAGNOSIS]. [NAME OF PATIENT] has been in my care since [DATE]. As a result of [DIAGNOSIS], my patient [ENTER BRIEF DESCRIPTION OF PATIENT HISTORY]. Additionally, [PATIENT] has tried [PREVIOUS THERAPIES] and [OUTCOMES]. The attached medical records document [PATIENT NAME]'s clinical condition and medical necessity for treatments with BENLYSTA.

Based on the above facts, I am confident that you will agree that BENLYSTA is indicated and medically necessary for this patient. The plan of treatment is to start the patient on BENLYSTA. Administration of BENLYSTA [DOSAGE] is planned on [DATE] and will be continued approximately every [FREQUENCY].

Please consider coverage of BENLYSTA on [PATIENT NAME]'s behalf, and approve use and subsequent payment for BENLYSTA as planned. Please refer to the enclosed Prescribing Information for BENLYSTA. If you have any further questions regarding this matter, please do not hesitate to call me at [PHYSICIAN TELEPHONE NUMBER]. Thank you for your prompt attention to this matter.

Sincerely,
[PHYSICIAN NAME], <DEGREE INITIALS>
[PROVIDER IDENTIFICATION NUMBER]
Enclosures (attach as appropriate):
FDA approval letter (available at http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm)
Prescribing Information (PI)
Clinic notes & labs
CC: [Medical Director, patient, specialty society, Insurance Commissioner]

Brackets indicate customizable fields to be filled out by healthcare provider.

1. Include any relevant information from the patient's medical records or chart for payers to review.

2. Ask your FRM for a copy of the full Prescribing Information or visit www.benlystahcp.com.

3. Check with the payer to identify any documentation that may need to be submitted with the Letter of Medical Necessity.

Please contact the payer, your GSK Field Reimbursement Manager (FRM), or your dedicated Site Coordinator at BENLYSTA Gateway at 1-877-4-BENLYSTA (1-877-423-6597), Monday-Friday, 8am-8pm ET, if you need any information about how to submit a Letter of Medical Necessity.