***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 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 [field of certification] with [XX] years of experience treating multiple sclerosis (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)]. The staff is very familiar with [his/her/their] health status and treatment plan, and I do not want any disruption to this continuity of care.

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 (e.g. distance or transportation)
  + Physical and cognitive limitations
  + Familiarity and comfort between patient site and patient, and/or potential disruption to multiple sclerosis treatment plan]
* [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]