

## SAMPLE LETTER OF MEDICAL NECESSITY

[Date]  
[Payer Name]  
[Payer Address]  
Attn: [Medical Director]

RE: [Patient Name]  
[Policy number]  
[Claim number, if applicable]

Dear [Medical Director]:

I am writing to provide additional information to support my claim for the treatment of [Patient Name] with [CUTAQUIG®, OCTAGAM®, PANZYGA®] [dosing] for [diagnosis code and description]. I believe the treatment of [Patient Name], DOB: [Patient DOB] with [CUTAQUIG, OCTAGAM, PANZYGA] is medically appropriate and necessary.

**[Exercise your independent medical judgment and discretion when describing the patient's history, diagnosis, and current condition; providing a summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with CUTAQUIG, OCTAGAM, or PANZYGA, etc]**

Based on my patient's history, current medical condition, and the published data supporting the use of [CUTAQUIG, OCTAGAM, PANZYGA], it is my professional opinion that treatment of [Patient Name], DOB: [Patient DOB] with [CUTAQUIG, OCTAGAM, PANZYGA] is medically appropriate and necessary.

Please call my office at [telephone number] if you require additional information or documentation. I look forward to your timely response.

Sincerely,

[Physician Name]  
[Telephone number]

**Enclosures [to be determined by physician]**

*[This document is provided as a sample template that may be used to appeal a payer coverage decision. The physician is responsible for the content of the letter that is customized to include information concerning an individual patient.]*

*[The information contained in this template letter is provided by Pfizer for informational purposes for patients who have been prescribed a Pfizer medicine. There is no requirement that any patient or healthcare provider use any Pfizer product in exchange for this information, and this template letter is not meant to substitute for a prescriber's independent medical decision-making.]*