Letter of Medical Necessity

[Physician Practice Letterhead]

[Date]
[Name of health insurance]
[Address]
[City, State, ZIP Code]

Insured: [Name]
Policy Number: [Number]
Group Number: [Number]

Dear Dr. [Medical Director's name],

I am writing to you on behalf of my patient, [Patient name], to request reconsideration of a claim. [Insurance company] has indicated that AJOVY™ (fremanezumab-vfrm) is not covered because [Reason for denial from Explanation of Benefits].

Summary of Patient History and Diagnosis

I have prescribed AJOVY based on the patient's history and diagnosis and have determined that AJOVY is medically necessary as part of this patient's treatment.

The following documentation further supports the medical necessity of this patient's treatment with AJOVY:

[List additional information attached to appeal including product information, published data regarding clinical utility, and medical records.]

Based on the above facts, I believe treatment with AJOVY is appropriate and medically necessary for this patient and would appreciate a reconsideration and approval of the treatment being requested. If you have any further questions, please feel free to call me at [Physician's telephone number, including area code] to discuss. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician name]