

Sample Letter of Medical Necessity

<<Date>>

<<Payer Name>>

<<Payer Address>>

Re: <<Patient Name>>

<<Date of Birth>>

<<Policy ID/Group Number>>

<<Name of Policyholder>>

Dear Sir/Madam:

This letter is on behalf of <Patient Name>, who is receiving treatment from me for <insert diagnosis for treatment as determined by the patient's physician>. I believe that treatment with XEOMIN® (incobotulinumtoxinA) is medically necessary and request that this patient receive coverage for this therapy.

<Provide description of patient's relevant medical history, including length of treatment for (insert diagnosis for treatment as determined by the patient's physician), prior medications that have been tried but have limited efficacy and/or side effects, other medical services associated with the patient's condition and impact of the diagnosis on the patient's quality of life.> By treating <Patient's Name> with XEOMIN, I anticipate the following outcomes <insert physician's professional opinion about the anticipated outcome of treatment>. <Discuss clinical judgment for use of XEOMIN and if appropriate, provide past clinical experience with botulinum toxin therapy>.

XEOMIN is approved for the treatment of adults with:

- chronic sialorrhea
- upper limb spasticity
- cervical dystonia
- blepharospasm

And children with:

- upper limb spasticity (age 2-17), excluding spasticity caused by cerebral palsy
- chronic sialorrhea (age 2-17)

I believe that XEOMIN is medically necessary for my patient. I have enclosed documentation supporting my clinical decision. If you require further information or documentation, please contact me at <phone number>.

Sincerely,

<<Physician Name>>

Enclosures:

<<List any included enclosures>>

The physician is responsible for all payer communications, including disclosure of personal health information.