# Sample Letter of Medical Necessity

The intent of this document is to provide you with a sample of information often required when submitting a letter of medical necessity. It is not a guarantee of coverage for your patient. The bracketed content is meant to provide guidance and should be substituted with the appropriate clinical information specific to your patient and their unique circumstance prior to submitting to the insurer. The contents of your letter must be based on your medical judgment and align with the patient’s medical records.

[Physician Letterhead]

[Insert Date]

[Payer Name]

[Street Address]

[City, State and ZIP Code]

RE: Documentation to Support Medical Necessity for [XPHOZAH® (tenapanor) \_\_ mg tablets]

Subscriber ID: [Subscriber/Member ID]

Patient Name: [Patient Name]

Patient DOB: [Patient DOB]

Physician TIN: [Physician TIN]

Physician NPI: [Physician NPI]

NDC: [Pre-populated XPHOZAH NDC]

To Whom It May Concern,

I am writing to you on behalf of my patient, [Patient Name], to request a reconsideration of coverage for [XPHOZAH (tenapanor) \_\_ mg tablets]. [Patient Name] is currently on dialysis with stage [\_] chronic kidney disease.

Your decision to deny coverage was based on [list denial reasons]. Please find below the patient’s relevant medical history, including diagnosis and labs, which support the use of XPHOZAH as medically necessary and an appropriate treatment plan.

Patient’s Medical History & Labs

[Patient Name] has been diagnosed with [diagnosis, including diagnosis code]. Recent labs indicate the following: [Insert Labs]

Additionally, [Patient Name] has previously been prescribed [insert prior treatments/medications] and has demonstrated an inadequate response to a phosphate binder therapy or intolerance to any dose of a phosphate binder therapy due to [insert reasons]. Furthermore, [Patient Name] is not a viable candidate for [insert applicable medication] because of [insert risk or reason, if applicable].

Based on my patient's medical history and prior medication(s) options [he/she] tried and failed, reconsider reversing the previous decision to deny XPHOZAH. If you require additional information or have questions, please do not hesitate to contact me at [Contact Phone Number] or [Contact E-mail Address].

Sincerely,

[Signature of Physician]

[Name and Credentials]

[Enclosures]

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