**Letter of Medical Necessity**

Date:

Payer Name:

Payer Address:

Payer City, State, ZIP Code:

Payer Phone Number:

Patient Name:

Patient DOB:

Policy #:

Group #:

To Whom It May Concern:

I am writing on behalf of my patient, (insert patient name), to provide supporting information for the treatment for multiple myeloma (MM) with Hemady® (dexamethasone) 20 mg tablets. Hemady® is a corticosteroid indicated in combination with other anti-myeloma products for the treatment of adults with multiple myeloma.1 This letter outlines the patient’s medical history and previous treatments to support the medical necessity of Hemady® therapy.

**Patient History, Diagnosis, and Clinical Recommendation**

Age: (insert patient age)

Diagnosis: (insert diagnosis)

Other relevant diagnoses:(insert other diagnoses)

Past steroid therapies for the treatment of multiple myeloma: (complete table below)

|  |  |  |
| --- | --- | --- |
| **Medication** | **Start/Stop Date** | **Reason for Discontinuation** |
|  |  |  |
|  |  |  |
|  |  |  |

Clinical rationale for the use of Hemady®: (insert rationale)

Please feel free to contact me at the phone number below for any additional information. Thank you for your prompt response to this matter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Provider Signature*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date*

Provider Name:

Provider Specialty:

NPI #:

Practice Name:

Practice Phone #:

Practice Fax #: