

Sample Letter of Medical Necessity  
*Patient to convert to OCREVUS or OCREVUS ZUNOVO*

[Date]

[Physician Name]

[Health Care Practice Name]

[Health Care Practice Address]

[City, State ZIP]

[Insured Name and DOB]

[Patient Name]

[Patient Insurance ID#]

[Reference Number, if Available]

Dear Medical or Pharmacy Director:

I have been treating my patient since [Date] to manage [his|her|their] disease. The patient has been on [his|her|their] currently utilized drug [Drug name] since [Date].

This letter of medical necessity is in regards to your coverage policy for [OCREVUS® (ocrelizumab)]OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)]. I have reviewed your drug coverage policy and feel that [Patient name and ID#] should be covered for [OCREVUS|OCREVUS ZUNOVO] as it is medically necessary to treat the patient's diagnosis of [relapsing forms of multiple sclerosis (RMS)|primary progressive MS (PPMS)] ([ICD-10-CM code]). The appropriate treatment for the patient at this time is to discontinue [Drug name] and to prescribe [OCREVUS|OCREVUS ZUNOVO].

My rationale for prescribing [OCREVUS|OCREVUS ZUNOVO] includes:

- [Reason(s) supporting changing to new drug prescription]

Included with this letter of medical necessity for the patient to change to [OCREVUS|OCREVUS ZUNOVO] are relevant supporting medical documentation, clinical trial information and FDA approval for the patient's diagnosis.

[Summarize reasons for the patient to convert to utilizing the recommended new drug]. Please feel free to contact me if I can provide further information or a peer-to-peer review for your approval of medical necessity for [OCREVUS|OCREVUS ZUNOVO].

Sincerely,

[Physician name]

[Phone number]

[Fax number]