

Sample Letter of Medical Necessity
Patient to remain on 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:

This letter of medical necessity is in regards to your coverage policy that does not provide coverage for [OCREVUS® (ocrelizumab)|OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)] for the treatment of [relapsing forms of multiple sclerosis (RMS)|primary progressive MS (PPMS)]. 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 their diagnosis of [RMS|PPMS] ([ICD-10-CM code]). I am requesting for the patient to be approved to continue on [OCREVUS|OCREVUS ZUNOVO].

I have been treating my patient since [Date] to manage their disease. My patient has been on [OCREVUS|OCREVUS ZUNOVO] since [Date]. [Describe the patient's experience with the drug.]

In my medical opinion, I believe that abandoning an effective drug therapy that is successfully treating my patient's disease is not the right choice based on my medical judgement for the following reason(s): [Insert reason(s)].

Included with this letter of medical necessity for the patient to be approved to continue their treatment of [OCREVUS|OCREVUS ZUNOVO] are relevant medical history notes, supporting clinical trials information and FDA approval data.

[Summarize the reason for the patient to remain on OCREVUS|OCREVUS ZUNOVO.] 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]