Sample Letter of Prior Authorization

[Date]
[Contact name of medical director or other payer representative]
[Contact title]
[Name of health insurance company]
[Address]
[City, State, Zip]
Re: Appeal for Prior Authorization for XERMELO® (telotristat ethyl)
Patient: [Patient name]
Group/policy number: [Number]
Date(s) of service: [Dates]
Diagnosis: [Code & description]

Dear [Contact name or department]:

I am writing on behalf of my patient, [patient name], to request prior authorization for the use of XERMELO® (telotristat ethyl) for the treatment of [indication].

Information related to the patient's medical history, prognosis, and treatment rationale are summarized below.
[Insert a narrative of the patient's medical history, including:]

- [Patient's diagnosis, condition, and treatment history]
- [Previous therapies the patient has undergone for the disease symptoms]
- [Patient's response to past tried and failed therapies]
- [Brief description of the patient's recent symptoms and conditions]

[Summarize your professional opinion of the patient's likely prognosis or disease progression without treatment with XERMELO].

Given [patient name]'s medical history and the indication for XERMELO, I am confident you will agree that XERMELO is medically necessary for my patient. Please do not hesitate to contact me at [physician's telephone number] if you require any further information to approve this request.

Sincerely,
[Provider name] [Degree initials]
[Provider identification number]

Enclosures: [Attach as appropriate]