Sample Letter of Medical Necessity

Accurate completion of reimbursement-related or coverage-related documentation is the responsibility of the provider and patient. Pfizer makes no guarantee regarding reimbursement for any service or item.

The information contained in this template letter is provided by Pfizer for informational purposes for patients who have been prescribed IBRANCE® (palbociclib). There is no requirement that any patient or healthcare provider use IBRANCE in exchange for this information, and this template letter is not meant to substitute for a prescriber's independent medical decision-making.

[Insert Physician Letterhead]

Attn: [Insert Name of Pharmacy Director]
[Insert Insurer/Health Plan Name]
[Insert Address]
[Insert City, State, ZIP]

RE: [Insert Patient Full Name]
[Insert Gender and Date of Birth]
[Insert Policy Number]
[Insert Group Number]

REQUEST: Authorization for treatment with IBRANCE
DIAGNOSIS: [placeholder for diagnosis] [Insert ICD-10-CM]
DOSAGE: [Insert dose, frequency, and days supplied]
REQUEST TYPE: ☐Standard ☐Expedited

[Insert Date]

Dear [Insert name]:
I am writing on behalf of my patient, [insert patient name], to document the medical necessity of IBRANCE. My request is supported by the following:

Summary of Patient's Diagnosis
[Insert patient's diagnosis, date of diagnosis, lab results and date, and current medical condition]

Summary of Treatment History [Exercise medical judgement and discretion when inserting the following:
- Diagnosis (ICD-10-CM) and dates of initial diagnosis and recurrence (if applicable)
- Confirmed biomarker status via FDA-approved test
- Laboratory/imaging results and pathology reports
- If applicable, prior treatments and procedures for the cancer (dosage, duration, clinical response, and reasons for discontinuation)
- Current condition, comorbidities, and intolerance to other therapies
- Physician opinion of patient prognosis or disease progression]

Rationale for Treatment

Considering the patient's medical history and current medical condition, I believe treatment with IBRANCE at this time is warranted, appropriate, and medically necessary for this patient.

The following documentation is enclosed:
- Full Prescribing Information for IBRANCE 125 mg capsules and tablets
- [Insert published articles and clinical guidelines (e.g., ASCO and NCCN)]
- [Insert laboratory/imaging results and pathology reports]
- [Insert medical records documenting treatment history]

Please contact me at [insert phone number or e-mail address] if you require any additional information or documentation. I look forward to your timely response.

If this request is denied, I am requesting an expedited review of appeal by a professional in my specialty.

Sincerely,
[Insert physician name and participating provider number]

Enclosure: [Include Full Prescribing Information for IBRANCE 125 mg capsules or tablets and any additional supporting documentation]

