



Please see below a sample letter of medical necessity for example purposes only. This sample letter provides insight into what plans may consider relevant information regarding your patient's treatment. Please note that submitting the information below to the health plan does not guarantee they will provide coverage for the prescribed medication, and some plans may require different or additional information. This example is not meant as a substitute for a prescriber's independent medical decision-making.

{Date Created}

{Provider_Full_Name}
{Site_Address1} {Site_Address2}
{Site_City}, {Site_State} {Site_Zip}

{Contact Name} (Usually the medical director)
{Title}
{Name of the Health Insurance}
{Address Street}
{Address. City, State and Zip Code}

Insured: *{Patient Name}*
Policy Number: *{Number}*
Group Number: *{Number}*

Dear Dr. *{Medical Director's Name}*,

I am writing to you on behalf of my patient *{Patient Name}* to request reimbursement for EPIDIOLEX[®] (cannabidiol). *{Patient's First Name's}* plan does not cover EPIDIOLEX at this time, however, it is my professional opinion as a specialist that it is medically necessary for him/her. *{Patient's First Name}* has been under my care since *[date]* for the treatment of *{Diagnosis}*.

Please see the attached documentation, regarding *{product name and/or patient's first name}* to assist with your coverage decision.

- Include rationale why this is medically necessary at the dosage prescribed
- List all *{patient's name}* previously tried and failed therapies (either for efficacy or tolerability)
- Include any pertinent diagnostic tests, such as EEG, MRI or genetic testing
- Provide reasons to substantiate why this would be the next logical step in your medical judgement to help the patient achieve better seizure control

This letter is being sent to you as part of the services of the JazzCares[®] Team and is intended for the addressee shown. It contains information that is confidential. For questions regarding this letter, refer to the contact information listed above. If you have received this letter in error, please immediately destroy it and notify the sender.

To learn more, patients please refer to EPIDIOLEX.com and US Healthcare Professionals refer to EPIDIOLEXhcp.com.

- Include any pertinent medical records that support your decision to prescribe EPIDIOLEX
- Include published data that you feel supports EPIDIOLEX use for the patient's condition
- Any other considerations for inclusion

Based upon the clinical rationale I have included, I request your approval of EPIDIOLEX as appropriate and medically necessary for my patient. If any further information is necessary for approval of this request, please feel free to call me at *{Prescriber's phone number}* to discuss.

Thank you in advance for your immediate attention to this request so that I may move forward with treating this patient as I deem necessary for their health.

Sincerely,

{Prescriber's Signature}

{Prescriber's Name}

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