Sample Letter of Medical Necessity—Doptelet® (avatrombopag)

[The following is a sample Letter of Medical Necessity. The text within pink brackets is templated and should be replaced with pertinent information for the individual patient on whose behalf you are submitting the letter. This paragraph and other italicized information within brackets are intended to provide additional guidance and should be omitted from the final letter. Healthcare providers should also consider using their organization's official letterhead.]

[Date]
[Payer Medical or Pharmacy Director Contact/Name]
[Payer Organization Name]
[Payer Street Address]
[Payer City, State, ZIP Code]

RE: [Patient Name]
Date of birth: [Patient's Date of Birth]
Policy ID/Group number: [Policy ID/Group Number]
Policy holder: [Policy Holder's Name]

Dear [Payer Medical or Pharmacy Director/Contact Name]:

I am [Physician Name**,** credentials, specialty, hospital/practice], and I am writing on behalf of my patient, [Patient Name], to document the medical necessity of Doptelet® (avatrombopag), which is prescribed to treat thrombocytopenia in adult patients with either chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment, or with chronic liver disease (CLD) who are scheduled to undergo a procedure.

1. Patient-Specific Rationale for Treatment
In brief, it is my medical opinion that initiating or continuing treatment with Doptelet for [Patient Name] is medically appropriate and necessary. Outlined below are [Patient Name]'s medical history and prognosis, and the rationale for treatment with Doptelet. The patient meets the following criteria for treatment: [List specific criteria here].

[Note: The following section is to be completed by the physician based on the patient's medical history and prognosis.]

2. Summary of Patient's Medical History *[You may be required to include:]*

- [Patient's diagnosis and current condition]
- [Relevant medical history or family history]
- [Previous therapies the patient has taken for the symptoms associated with chronic ITP or CLD]
- [Clinical notes]

3. Doptelet Dosing Information

[Note: Mention the starting dose and potential duration of therapy for Doptelet. You may choose to include details from the Prescribing Information attached to the end of this sample letter.]

Please call my office at [telephone number] if you require additional information. I look forward to receiving your timely response and approval of this authorization.

Sincerely,
[Physician Name]
[Title, Institution]
[Email/Phone Number]

[Note: Attach full Prescribing Information.]