[Date]
[Health plan name]

ATTN: [Contact title/medical director]
[Contact name (if available)]
[Health plan address]
[City, State, ZIP]

Re: Letter of Medical Necessity for DRIZALMA SPRINKLE™ (duloxetine delayed-release capsules)

[Patient name]
[Date of birth]
[Insurance ID number]
[Insurance group number]
[Case ID number]
[Date of service]

Dear [Contact name/Medical director],

This letter is sent on behalf of [patient's name] to document that [he/she] has clinical rationale for Drizalma Sprinkle™. I am writing to document my patient's medical history and diagnosis and summarize my treatment rationale. Treatment with Drizalma Sprinkle™. [dose, frequency] is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old [gender] who was diagnosed with [x] on [date]. [Patient's name] has been in my care since [date]

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

Considering my patient's history, condition, and the full Prescribing Information supporting the use of Drizalma Sprinkle™ I believe treatment with Drizalma Sprinkle™ is appropriate, medically necessary, and should be covered and reimbursed. Enclosed you will find other relevant supporting documentation.

Please contact my office by calling [phone number] for any additional information you may require. I look forward to your timely approval.

Sincerely,
[Physician's signature]
[Physician's name]

Suggested enclosures:
Package insert for Drizalma Sprinkle™
Copy of patient medical records
Other supporting documentation

PM-US-DRI-0008 09/2019