

Sample Letter of Medical Exception for MonoferriC

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when requesting a formulary exception from a patient's insurance company. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence, the independent clinical decision of the prescribing healthcare professional.

[Physician or Practice Letterhead]

[Date]

[Health Plan Name]

ATTN: [Department]

[Medical Director Name]

[Health Plan Address]

[City, State ZIP]

RE: Patient Name _____
Date of Birth _____
Policy Number _____
Claim Number _____

Re: Letter of Medical Exception for MonoferriC® (ferric derisomaltose)

Dear **[Medical Director Name]**,

My name is **[Physician Name]** and I am a **[board-certified medical specialty] [NPI]**. I am writing to request a formulary exception for my patient, **[Patient Name]**, who is currently a member of **[Health Plan Name]**.

The prescription is for MonoferriC, which is medically appropriate and necessary for this patient who has been diagnosed with **[condition]**, **[ICD code(s)]**. Therefore, I am requesting that **[Health Plan Name]** remove any medical policy or guideline requirements in this case so that MonoferriC can be made available to my patient as a preferred medication.

Summary of Patient's History

[Must include: Patient's clinical / medical history, diagnosis, condition, and symptoms:]

[Patient Name] is **[a/an]** **[age]**-year-old **[male/female]** patient who has been diagnosed with **[condition]****[ICD-10-code(s)]** as of **[date of diagnosis]**. **[He/she]** has been in my care since **[date]**.

[Include any additional considerations here:]

- ☐ [Previous treatments including drug names, duration of treatment(s), responses to those treatments (see table below)]
- ☐ [Acute and chronic complications associated with the patient's iron deficient anemia]
- ☐ [Treatment plan: expected duration of treatment or number of infusions requesting medical exception for]

My rationale for prescribing MonoferriC is based on **[include a brief disease course of patient, including history of disease, laboratory results, symptoms, and previous treatments (including names, dosages, frequency, and length)]**. If the patient has discontinued treatment, please include information on the

reasons for such discontinuation (see table below). You may also want to include medical reasoning for choosing to bypass any alternative medications preferred by the health plan such as COVID-19 risk exposure, or other infectious diseases, due to multiple infusions, patient may not be able to comply with labeled multiple dosing requirements of preferred products over an extended period of time, and treatment guidelines such as NCCN, KDIGO, and NICE.]

[Please exercise your medical judgment and discretion when providing diagnosis and characterization of the patient's medical condition].

Past Treatment(s)	Start/Stop Dates	Reason(s) for Discontinuing
[Drug name]	[MM/YY] – [MM/YY]	[Please list reasons]
[Drug name]	[MM/YY] – [MM/YY]	[Please list reasons]

Based on the patient's condition and my experience treating patients with [diagnosis] I have concluded that Monoferric is medically appropriate in this case. I further attest [include physician expectations regarding clinical outcomes for patient].

I am requesting an immediate and expedited review of this request by a board certified and specialty matched physician who can render a decision based upon the standards of care outline above. If you have any questions, please contact me at [Physician Phone Number] for a peer-to-peer discussion. I would be pleased to speak to you in more detail about why a Monoferric formulary exception is necessary for [Patient Name]'s treatment of [diagnosis].

If you do not feel that the information provided has established medical necessity, please provide me with your detailed rationale based upon the standards of care, the specialty of the physician who reviewed this case, and whether they are board certified in an appropriate medical specialty.

I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Physician name]

[Physician signature]

[Physician address]

[Physician phone number]

Enclosures

[List enclosures, which may include medical records, clinical notes/diagnostic report, medication records, relevant laboratory reports that support the need for Monoferric, Monoferric Prescribing Information, letter of medical necessity and other supporting documentation].