# SAMPLE LETTER OF MEDICAL NECESSITY

[Date]
[Payer Name]
[Payer Address]

Attn: [Medical Director]

RE: [Patient Name]
[Policy number]
[Claim number, if applicable]

Dear [Medical Director],

I am writing to provide additional information to support my claim for the treatment of [Patient Name] with [XELJANZ® (tofacitinib) tablets/XELJANZ® XR (tofacitinib) extended-release tablets] [dosing] for [diagnosis code and description]. I believe treatment of [Patient Name] with [XELJANZ/XELJANZ XR] is medically appropriate and necessary, and should be a covered and reimbursed service.

[Provide a description of patient's relevant medical history based on your clinical judgement such as:]

- [Patient demographics, diagnosis, recent symptoms/condition and history]
- [Prior medications that have been tried, and patient's response to these therapies]
- [Patient contraindications or intolerances to prior therapies]
- [Patient diagnostic test results]
- [Impact of the diagnosis on patient's quality of life]
- [Anticipated prognosis without XELJANZ/XELJANZ XR]

Based on my patient's history, current medical condition, and the published data supporting use of [XELJANZ/XELJANZ XR], it is my professional opinion that treatment of [Patient Name] with [XELJANZ/XELJANZ XR] is medically appropriate and necessary.

Please call my office at [telephone number] if you require any additional information or documentation. I look forward to your timely response.

Sincerely,
[Physician Name]
[Telephone number]

Enclosures [to be determined by physician]

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