[INSERT ON PROVIDER LETTERHEAD]

[Date]
[Claims department]
[Name of health plan]
[Mailing address]

RE: [Patient name]
Policy number: [Policy number]
Claim number: [Claim number]

Dear [Medical director],

This letter is sent on behalf of [patient's name] to request coverage for [product name] for the treatment of [add diagnosis and diagnosis code].

[Patient's name] is [a/an] [age]-year-old [male/female] who was diagnosed with [add diagnosis] on [date]. [Patient's name] has been in my care since [date] and has previously tried and failed on multiple other treatments including [list any previous treatments].

[Patient's name] meets your prior authorization criteria of:

- Diagnosis of [add diagnosis]
- Patient is 12 years of age or older
- [other applicable authorization criteria, including trial and failure of previous therapies and/or other contraindicated therapies]

[Provide a summary of the patient's medical history and current condition, and what factors led you to recommend the use of [product name]. 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.

Enclosures: [Product Prescribing Information, clinical notes/medical records, American Academy of Dermatology clinical practice guidelines, other supporting documentation]

Sincerely,

[Physician signature]
[Insert name]

*NOTE: This sample letter and related information are provided for informational purposes only. It is the responsibility of the HCP and/or their office staff, as appropriate, to determine the correct diagnosis, treatment protocol, and content of all such letters and related forms for each individual patient and submit. Bausch Health does not guarantee coverage or reimbursement for the product.

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