**Instructions:**

Please note that this is a template only to be used in response to a request from a healthcare provider for a sample resource that could be used by a healthcare provider when responding to a request of medical necessity with regards to a patient's health benefits and an AstraZeneca medicine. **Attachments to be included with the letter of medical necessity are [original claim form, copy of denial or explanation of benefits, and any other additional supporting documents].** If you need additional references, please contact our information center at 1-800-236-9933.

**Use of the letter does not guarantee that the insurance company will provide reimbursement for AstraZeneca medicines, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider**.

## Sample Renewal Authorization Letter

(Healthcare Provider Letterhead)

**Date: [Date]**
**Payer Name: [Payer Name]**
**Payer Address: [Payer Address]**
**City, State, ZIP Code: [City, State, ZIP Code]**
**Payer Phone and Fax Number: [Payer Phone and Fax Number]**
**Patient Name: [Patient Name]**
**Patient Date of Birth: [Patient Date of Birth]**
**Policy Number: [Policy Number]**
**Group Number: [Number]**

Dear **[Name of the Contact Person at the Insurance Company]**:

I am writing on behalf of my patient, [Patient Name] to document the ongoing medical necessity of FASENRA® (benralizumab) Subcutaneous Injection 30 mg for the treatment of [Diagnosis]. This letter provides information about the patient's medical history, diagnosis, response to treatment, and a statement summarizing my treatment rationale.

**Patient History and Diagnosis**

[Explain why you believe it is medically necessary for the patient to remain on this medicine.]
[Describe the potential consequences if the patient does not receive this medicine.]
[Include a Short Summary of the patient's medical history pre and post FASENRA including lab results displaying patient's diagnosis.]
[Provide documentation detailing any hospitalizations, emergency room/urgent care visits or unscheduled visits due to their condition within the past 12 months.]

**Treatment Rationale**

[Include information on the treatment up to this point, course of care and why maintaining this treatment/medication regimen is necessary and how you expect it will help the patient.]

To conclude, FASENRA is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of FASENRA.

Sincerely,

[Physician's Name]
[Physician's Practice Name]

**Enclosures**

[Include Indication and Important Safety Information]
[Include full Prescribing Information, including Patient Information]

**References**

[Include medicine PI]
[Include other relevant references and publications regarding medicine]