**Sample Letter of Medical Necessity**

**Template Instructions:**

This template is offered as a resource a healthcare provider could use when responding to a request from a patient’s health benefits company to provide a letter of medical necessity for prescribing LOKELMA® (sodium zirconium cyclosilicate). As you review the template below, please note that you will need to populate or provide the information in bracketed pink font ([xxx]).

**Documents typically included with the letter of medical necessity are a copy of the denial or explanation of benefits, any supporting documents, and Prescribing Information.** If you have questions, please contact our Information Center at 1-800-236-9933.

**Use of the Letter of Medical Necessity does not guarantee that the insurance company will approve your request for LOKELMA and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.**

**IMPORTANT NOTE: This template is intended to be completed by the patient’s treating physician. Prior to submission, please delete these instructions and complete all sections below.**

***[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:** [Group Number]

**RE: Letter of Medical Necessity for LOKELMA® (sodium zirconium cyclosilicate)**

Dear [Name of the Contact Person at the Payer]:

I am writing on behalf of my patient, [Patient Name] to document the medical necessity of LOKELMA for the treatment of [Specific Diagnosis]. This letter provides information about the patient’s medical history and diagnosis and a statement summarizing my treatment rationale.

**Patient History and Diagnosis**

[Provide a Brief Description of the Patient’s Medical Condition Here.]

[Include a Short Summary of the Patient’s Medical History including lab results and failed medicines as applicable.]

[Explain why you believe it is Medically Necessary for Patient to receive this Medicine.]

[Describe the Potential Consequences of the Patient if they do not receive this Medicine.]

[Obtain and Attach Supporting Letters from any other Specialist(s) that is currently or has previously provided Care to the Patient.]

[Include Medicine Indication Information]

[Include Medicine Administration Information]

To conclude, LOKELMA is medically necessary for this patient’s medical condition. Please contact me at [Provider Phone Number] if any additional information is required to ensure the prompt approval of LOKELMA for this patient.

Sincerely,

[Physician’s Name]

[Physician’s Practice Name]

References

[Include LOKELMA PI]

[Include other relevant references and publications regarding LOKELMA]