Instructions:

This template is offered as a resource for a healthcare provider to potentially use when responding to a request from a patient's health benefits company to provide a letter of medical necessity for prescribing Rezdiffra™ (resmetirom). **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 medical information team at 1-800-905-0324.

The use of the letter does not guarantee that the insurance company will provide coverage for Rezdiffra™ (resmetirom) and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Medical Necessity
(*Healthcare Provider Letterhead*)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone: [Payer Phone]
Payer Fax: [Payer Fax]

Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]
BIN 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 medical necessity of Rezdiffra™ (resmetirom) for the treatment of <indication>. This letter provides information about the patient's medical history and diagnosis, along with a statement summarizing my treatment rationale.

Patient History and Diagnosis
[Provide a brief description of the patient's medical condition]
[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 Rezdiffra™ (resmetirom)]
[Describe the potential consequences for the patient if they do not receive Rezdiffra™ (resmetirom)]
[Obtain and attach supporting letters from any other specialist(s) that is currently or has previously provided care to the patient]
[Include Rezdiffra™ (resmetirom) indication information]
[Include Rezdiffra™ (resmetirom) administration information]

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

Sincerely,

[Physician's Name]
Physician Signature: _____
[Physician's practice name, address, phone number]

References
[Include Rezdiffra™ (resmetirom) Prescribing Information]
[Include other relevant references and publications regarding Rezdiffra™ (resmetirom)]