**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 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 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 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 medical necessity of FASENRA® (benralizumab) Subcutaneous Injection [Strength] for the treatment of [Diagnosis]. This letter provides information about the patient's medical history and diagnosis and a statement summarizing my treatment rationale.

**Patient History and Diagnosis**

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

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

[Include a Short Summary of the Patient's Medical History, including lab results displaying patient's diagnosis.]

[Include a list of previously used maintenance treatments, including high-dose inhaled corticosteroids and/or additional controller medications.]

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

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[Provide documentation detailing any hospitalizations, emergency room/urgent care visits or unscheduled visits due to their condition.]

**Treatment Rationale**

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

**Primary Care Providers**

[Include consultation notes from discussion with Specialist]

To conclude, FASENRA® (benralizumab) 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® (benralizumab).

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]

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