**Letter of Medical Necessity**

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| --- | --- |
| Date:  |  |
| Re: | Patient Name:  | Gender:  |
|  | Patient Address: |
|  | Patient Date of Birth:  | Insurance Plan #: |
|  | Insurance Identification # (Member/Group ID#):  |
|  | Is Insurance a commercial plan or Medicare part D?  |
|  | Pharmacy Name:  | Pharmacy Phone Number:  |

To Whom It May Concern:

This letter serves as a request and clinical justification for the above referenced patient to begin treatment with [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] (glucagon injection). Following a complete medical assessment, I have deemed [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] an appropriate treatment medication.

Patient profile:

Diagnosis (please specify):

Current medications:

Patient was previously treated with:

Reason for discontinuation or change in therapy:

Prescribed [Gvoke HypoPen® and/or Gvoke® Pre-Filled Syringe] use (including dosage information and therapy dates):

[Provide any other reasons why this medication was prescribed, including information on patient’s condition and previous medications.]

I have enclosed copies of pertinent medical notes as well as laboratory and other test results for your reference. I have also enclosed patients’ current condition and clinical assessment as rationale for treatment as well as attached past hypoglycemic event information to justify new auto injector technology if applicable.

I certify that this information is correct. If you have any questions about this request, please feel free to contact me. I would be more than willing to discuss this specific case with you.

Sincerely,

[Physician’s Name]
[Address, Phone and Fax Number]

|  |  |
| --- | --- |
|  DEA #:  | NPI #: |

Please attach past hypoglycemic event information to justify new auto injector technology if applicable