**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