

Sample Statement of Medical Necessity Letter

[Note: This letter should be written on practice letterhead after fully reviewing the health plan's medical policy]

[Date] Patient Name: [_____]
[Insurance Company] Policy #: [_____]
[Street Address] Group #: [_____]
[City, State, ZIP Code] Date of Birth: [_____]

RE: Statement of Medical Necessity for FILSPARI™ (sparsentan)

To Whom It May Concern:

I am writing on behalf of [insert patient name] to request prior authorization and provide documentation of the medical necessity for treatment with FILSPARI™ (sparsentan). The patient was referred to me by [if applicable, insert referring physician]. [Insert a brief statement about the patient's diagnosis, medical history, and the severity of their condition.]

Following is a list of the patient's current and past medications.

| Treatment(s) | Start Date | Stop Date | Discontinuation Reason |
|--------------|------------|-----------|------------------------|
| | | | |
| | | | |
| | | | |

I have reviewed the FILSPARI™ (sparsentan) Prescribing Information and based on my clinical judgment, I believe the following treatment plan is indicated and medically necessary for [insert patient name]:

[Insert medication, dosage, quantity, estimated duration of therapy, and drug NDC number].

If you require additional information, please contact me at [Physician's telephone and office email].

Please note the following attachments:

- [Relevant clinical documentation to support medication use – medical records, progress notes, and lab reports. For example, record of kidney biopsy, current proteinuria & eGFR levels, documented use of RAASi, REMS enrollment confirmation, etc.
- Prescribing Information
- FDA Product Approval Letter]

Thank you for your consideration.

Sincerely,

[Insert Physician's Name]