LETTER OF MEDICAL NECESSITY
[To be completed by prescriber and printed on letterhead]

[Date]

[Name of Health Insurance Company]
[Attn:]
[Address]
[City, State, ZIP]

Re: Letter of Medical Necessity for QUTENZA® (capsaicin) 8% Topical System

Patient: [Patient Name]
Group/Policy Number: [Number]
Diagnosis: [Code and Description]
Date of Diagnosis: [Date]

Dear [Insert contact name or department]:

I am writing on behalf of my patient, [Patient Name], to document medical necessity for treatment with QUTENZA® (capsaicin) 8% topical system. [Patient Name] was first diagnosed with [The patient's diagnosis (ICD-10-CM code)] on [date of diagnosis]. Therapies prescribed to treat the condition include [list the names of current or past treatments].

At this time, I plan to start [Patient Name] on a course of treatment with QUTENZA.

[Patient Name] will be treated with [two/three/four] systems on [specify treatment area(s)] for [number of treatment cycles] treatment cycles.

[Insert a statement describing how the patient's disease is impacting the patient's health.]

In my professional opinion, QUTENZA is medically necessary and is an appropriate drug for [Patient Name] at this time. I have enclosed the prescribing information for QUTENZA along with [Patient Name]'s [list pertinent enclosures such as prior medication flow sheets and chart notes]. Please feel free to contact me if you require any additional information.

Sincerely,

[Physician Name]
[Physician Signature]
[Provider Identification Number]

Enclosures: [List and attach as appropriate]

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