

LETTER OF MEDICAL NECESSITY

DATE:

TO:

FROM:

PATIENT:

INSURANCE ID:

SUBSCRIBER:

DOB:

GROUP NO:

To Whom It May Concern:

XYZ is a _____ year old patient with a rare disorder (or inborn error of metabolism) called Glutaric Aciduria Type 1 (GA). This disorder is a type of _____ whereby the affected individual is unable to _____. The purpose of this letter is to explain the medical necessity of a treatment I am ordering for this patient which is imperative in the management of this condition. It is a specialized metabolic formula called GA gel.

The accepted standards of care to treat this disorder consist of a diet low or void of the amino acid(s) lysine and tryptophan. Therefore, adequate protein intake and utilization is not possible without the use of a protein substitute/specialized metabolic formula. Without adequate protein intake, the body _____ and this can cause _____. Without proper medical treatment, XYZ is at risk for _____ and other negative symptoms from his/her disease. This could lead to (hospital admissions, expensive diagnostic testing and critical consequences).

In XYZ's situation we have noted (_____ labs up/down, weight loss, feeding issues, behavioral issues, taste burnout with current metabolic supplement/formula, inability to meet caloric needs, muscle wasting, fullness from certain formulas or those that must be taken in addition to food adding volume, other documented issues). This product is needed to assist in: (_____ meeting calorie needs, meeting overall protein needs, prevent vitamin/mineral deficiencies, reduce potential complications of this disorder, decrease need for medication/other treatments, prevent more expensive treatment options such as: _____). The use of prescription specialized medical formulas has shown positive outcomes in evidenced-based research.

GA gel is a powdered metabolic formula that is lysine free and low in tryptophan, and provides the necessary mixture of amino acids, carbohydrates, minerals, trace elements and vitamins to meet XYZ's daily nutritional needs. It is manufactured by VitaFlo USA, LLC (1-888-VITAFLO). HCPCS is B4155. Reimbursement code: 50600-0536-02.

The attached prescription is for XYZ to take _____ sachets per day in order to meet his/her protein (and calorie) intake needs. This patient has already sampled GA gel and it has been tolerated and accepted well.

I appreciate your consideration with this request. Your authorization of the prescription will provide this patient the treatment needed to improve his/her medical situation, resulting in an overall cost savings to your company. Please feel free to contact me if you have additional questions.

Sincerely,
Name of Physician