

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 _____. 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 formula called Lipistart.

The accepted standards of care to treat this disorder consist of a diet _____. Since most sources of dietary fats come in the form of long chain fats, adequate fat intake and utilization is not possible without the use of a medium chain fat supplement. Without adequate fat 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, taste burnout with current oral formula/supplements, inability to meet caloric needs, gastrointestinal issues, muscle wasting, fullness from certain supplements 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, shorten recovery time, meet overall fat needs, prevent fat soluble vitamin deficiencies, speed healing, promote weight gain, reduce potential complications of this disorder, decrease need for medication/other treatments, prevent more expensive treatment options such as: _____). The use of prescription medical supplements has shown positive outcomes in evidenced-based research.

Lipistart is a nutritionally complete powdered formula that is high in medium chain fats and low in long chain fats. It is manufactured by VitaFlo USA, LLC (1-888-VITAFLO). HCPCS is B4150 (adult) & B4158 (pediatric). Reimbursement code: 50600-0502-05

The attached prescription is for XYZ to take _____ servings per day in order to meet his/her fat (and calorie) intake needs. This patient has already sampled Lipistart 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