Date

Pre-Service Review Department
[Insurance Company Name]
[Address]
[City, State and ZIP Code]

Re: [Patient's Name]
Member ID: [Member ID or Medicare Number]

Group Number: [Group number/Policy number]

**Subject: Statement of Medical Necessity for** [Type of Hematopoietic Stem Cell Transplant]

Dear Authorization Reviewer:

I am requesting approval for an [allogeneic, autologous] hematopoietic stem cell transplant for my patient, [Patient's Name], to take place [indicate approximate date/timeframe].

[Patient's Name] has been under my care for [name of diagnosis, short description, which is [life threatening?] condition in [stage of disease?] that causes [insert a description of patient’s S/S and stage of illness, etc.]. Without a transplant this patient [what is prognosis without transplant?]

[Indicate here if the patient has had and failed prior treatment – describe what the treatment was and the current state of the patient’s disease.]

**OR**

[Indicate here what alternative treatments are and why they are not appropriate for this patient.]

HCT [offers patients with this condition the only chance of cure?] Or, HCT [Is the standard of care for this condition] – explain in detail why transplant is the best treatment choice]. With transplant, the likely outcome for [Patient’s Name] is [insert likely outcomes and longevity and data if you have it here].

Transplant for [insert condition] is accepted as the standard of care, and is well supported by respected scientific literature. [Summarize literature findings here.]

[If appropriate] Please review the following enclosed medical journal articles that support this treatment for this condition:

* **Article #1**
* **Article #2**
* **Article #3**

**OR**

Due to the small number of patients with this [deadly? rare?] disease it is not possible to obtain enough participants for a clinical trial, hence we must rely on small case series to guide treatment. [Summarize published findings.] [Explain why you are taking the approach you are.]

Based on the available evidence on [Patient's Name's] condition, I am filing this request, specifically asking for coverage for [transplant type] for [Patient’s Name]. This treatment will be performed in an [inpatient OR outpatient] setting. As I stated above, [transplant type] is the [only available or best] treatment option for this patient. Not approving this transplant leaves this patient with [insert prognosis here].

I welcome a telephone discussion if that will help you in any way. You can reach me at XXX-XXX-XXXX or via cell phone at XXX-XXX-XXXX.

Sincerely,

[Physician's Name]**, M.D.**

**Enclosures:**

1. Documents referred to in text.
2. Completed Appointment of Representative Form