

Sample Letter of Medical Necessity  
*Patient New to OCREVUS or OCREVUS ZUNOVO*

[Date]

[Physician Name]

[Health Care Practice Name]

[Health Care Practice Address]

[City, State ZIP]

[Insured Name and DOB]

[Patient Name]

[Patient Insurance ID#]

[Reference Number, if Available]

Dear Medical or Pharmacy Director:

This letter of medical necessity is in regards to your coverage policy for [OCREVUS® (ocrelizumab)]OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)] for the treatment of [relapsing forms of multiple sclerosis (RMS)]primary progressive MS (PPMS)]. I have reviewed your drug coverage policy and feel that [Patient name and ID#] should be covered for [OCREVUS|OCREVUS ZUNOVO] as it is medically necessary to treat the patient's diagnosis of [RMS|PPMS] ([ICD-10-CM code]).

The patient's symptoms and MS disease summary are:

- [MRI scan documentation and findings]
- [MS severity overview including disability status if relevant]
- [Past drugs and treatments that were tried and failed]
- [Allergic or skin reactions to certain medications]
- [Activities of daily living affected by current MS disease]

The medical rationale for prescribing [OCREVUS|OCREVUS ZUNOVO] are:

- [Drug treatment recommendation for the patient]
- [Overview of the drug and its effectiveness for treating MS based on clinical trial results]
- [Supporting clinical trial data]
- [FDA approval data]

I have included relevant medical documentation, supporting clinical trial data and a copy of FDA approval supporting my request for medical necessity approval for [OCREVUS|OCREVUS ZUNOVO]. Please feel free to contact me if I can provide further information or a peer-to-peer review for your approval of medical necessity for [OCREVUS|OCREVUS ZUNOVO].

Sincerely,

[Physician name]

[Phone number]

[Fax number]