**Sample Letter of Medical Necessity**

This sample letter is for demonstration purposes only. Use of this template or the information in this template does not guarantee coverage. It is not intended to be a substitute for, or to influence the independent clinical decision of the prescribing healthcare professional.

[Date] Name: [Patient’s Name]

[Health Plan Name] ICD-10 code: [XXX.X]

ATTN: [Department] DOB: [XX/XX/XXXX]

[Medical/Pharmacy Director Name] Patient Policy ID Number: [Policy ID #]

[Health plan address] Reference Number: [Reference #]

[City, State Zip] Date(s) of Service: [XX/XX/XXXX]

Re: Letter of Medical Necessity for [COBENFYTM (xanomeline and trospium chloride)]

Dear [Insurance Company Contact]:

I am writing on behalf of my patient, [Patient’s First and Last Name], to demonstrate the medical necessity and support for the coverage of [COBENFYTM (xanomeline and trospium chloride) capsules] for schizophrenia, [ICD-10-CM code].

COBENFYTM is an oral, twice-daily, muscarinic medication that was approved by the US Food and Drug Administration (FDA) in September 2024 for the treatment of schizophrenia in adults.

**Summary of treatment rationale:**

In this letter, I provide my rationale for the use of COBENFYTM by [Patient’s First and Last Name]. I have also included a brief description of the patient’s medical history, including prior therapies, and [his/her] current condition and diagnosis.

[Provide details on the patient’s diagnosis, current condition, home environment/caregiver situation, symptoms, treatment history, and support for approval. You may want to include

* Records indicating the patient’s diagnosis and the date of diagnosis
* Rationale for treatment
* Brief description of the patient’s disease state
* Comprehensive list of any prior treatments and response to those treatments
* Rationale for selecting COBENFYTM
* Additional medical documentation or medical literature that support your argument for approval

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

I am requesting support for this coverage because [insert summary of professional opinion of the patient’s likely prognosis and/or disease progression without treatment with COBENFYTM].

Please contact my office by calling [practice phone number] for any additional information you may require.

Sincerely,

[Physician’s Signature]

[Physician’s Name]

[Provider Identification Number]

[Name of Practice]

[Phone Number]

Enclosures: [(attach as appropriate)

* COBENFYTM full Prescribing Information
* Patient clinical/diagnostic notes and relevant lab reports]