Sample Letter of Medical Necessity

On the following page, you will find a sample Letter of Medical Necessity. This sample letter is intended as an example for healthcare providers who have prescribed BRIXADI™ (buprenorphine) extended-release injection for subcutaneous use CIII and want to request a payer to approve coverage for a patient.

This letter should be customized by you or your staff to reflect the specific requirement of the payer. Braeburn recommends confirming the information that is required in a Letter of Medical Necessity with individual payers. The sample letter may not include all topics required by a payer. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence the independent clinical judgement of the prescribing healthcare professional.

Please see FULL PRESCRIBING INFORMATION, including BOXED WARNING.

MLR-1060 May 2023

Sample Letter of Medical Necessity

[PHYSICIAN LETTERHEAD]

[Date]
[Medical Director]
[Insurance Company]
[Address]
[City, State, ZIP]

RE: Patient: [Insert Patient Name], Policy Number: [Insert Policy Number]

Subject: Letter of Medical Necessity for BRIXADI™ (buprenorphine) extended-release injection for subcutaneous use CIII

Dear [Insurance Company Contact]:

I am writing on behalf of my patient, [Patient Name] to document the medical necessity for treatment with BRIXADI (buprenorphine) extended-release injection for subcutaneous use CIII for [Patient Diagnosis].

This letter provides information about the patient's medical history and diagnosis, and a statement summarizing my treatment rationale.

Patient History and Diagnosis:

- [Patient's diagnosis, date of diagnosis]
- [Brief description of patient's medical condition]
- [Patient's previous and current treatment/therapies]
- [Rationale for treatment]

Considering the patient's medical history, current medical condition, and indicated uses of BRIXADI, I believe treatment with BRIXADI at this time is warranted, appropriate, and medically necessary for this patient.

Please contact me if any additional information is required to ensure the prompt approval of this course of treatment.

Sincerely,
[Physician Name]
[Physician Practice Name]
[Physician Phone Number]