[INSTITUTION LETTERHEAD]

[Neurologist's Name, Credentials]
[Practice or Hospital Name]
[Address]
[City, State, ZIP]
[Phone Number]
[Fax Number]
[Email Address]

[Insert Date]

To: [Medical Director or Insurance Company Name]
[Insurance Company Address]
[City, State, ZIP]

Re: Letter of Medical Necessity for [Patient's Full Name]
DOB: [MM/DD/YYYY]
Insurance ID: [Patient's Member ID]
Diagnosis: Neuromyelitis Optica Spectrum Disorder (NMOSD), ICD-10 Code G36.0

To Whom It May Concern,

I am writing on behalf of my patient, [Patient's Full Name], who has been under my care since [Insert Year], to appeal the recent denial of coverage for [Name of Medication – e.g., satralizumab (Enspryng), eculizumab (Soliris), or inebilizumab (Uplizna)]. This medication is medically necessary for the ongoing, life-saving treatment of [Patient's Name]'s neuromyelitis optica spectrum disorder (NMOSD), a rare, relapsing autoimmune disease of the central nervous system that disproportionately impacts the optic nerves and spinal cord.

NMOSD is a severe and often disabling condition with a high risk of permanent vision loss, paralysis, respiratory failure and even death if not adequately treated. Unlike multiple sclerosis, relapses in NMOSD are typically more destructive and do not remit fully, leading to cumulative and irreversible neurological damage with each episode. Preventing relapses is the cornerstone of effective treatment and is essential to preserving both quality of life and long-term function.

[Patient's Name] has tested positive for AQP4-IgG antibodies, confirming the diagnosis under current diagnostic criteria. They have already experienced [X number] of documented relapses, resulting in [describe functional impairments – e.g., partial vision loss, bladder dysfunction, limb weakness, etc.], which underscores the aggressive nature of their disease.

The requested therapy, [Medication Name], is FDA-approved specifically for the treatment of AQP4-positive NMOSD and has been shown in pivotal trials (e.g., [Name of Trial, if known]) to significantly reduce the risk of relapse, hospitalization, and disability progression. No alternative treatment offers comparable efficacy or safety in this patient population. [Patient's Name] has either failed or is not a candidate for [list any prior therapies—e.g., rituximab, corticosteroids, IVIG, etc.], further reinforcing the need for long-term treatment with [Medication Name].

Denying coverage for this evidence-based, guideline-supported therapy places my patient at unacceptable medical risk, including blindness, paraplegia and death. The chronic nature of NMOSD and the catastrophic consequences of relapse necessitate ongoing access to this therapy as a medically necessary, life-sustaining treatment.

In light of the clinical severity of NMOSD and the overwhelming evidence supporting [Medication Name] as a standard of care, I respectfully urge you to reverse the denial and approve coverage immediately. I am available to provide additional documentation, medical records or to discuss this matter directly should that be required.

Thank you for your urgent attention to this matter on behalf of my patient.

Sincerely,

[SIGNATURE]

[Neurologist's Name, Credentials]
[Practice or Hospital Name]
[Address]
[City, State, ZIP]
[Phone Number]
[Fax Number]
[Email Address]