[OFFICE LETTERHEAD INCLUDING PROVIDER NAME AND ADDRESS]

Statement of Medical Necessity

[Date]

[Name of Health Insurance Company]

[PO Box or Street Address]

[City] [State] [Zip Code]

Re: [Patient name] Policy Number: [ ] Group Number: [ ]

To Whom It May Concern:

[Patient name] is currently under my care for [insert diagnosis]. The diagnosis was made on [Date], after the following testing was completed: [List sequence of medical testing that led to diagnosis].

To date, the patient has been treated for the above mentioned condition with the following: [List all treatments (minimum of two prior therapies) implemented and corresponding dates].

In my professional opinion, [Immunomedics product] is medically necessary for [Patient name] and is an appropriate therapy at this time due to [Patient's Name's] failure on at least two prior therapies.

Enclosed you will find applicable information about the patient, including [List pathology reports, other findings, and chart notes]. The prescribing information for [Immunomedics product] is also enclosed.

Please feel free to contact me at [insert phone number] if you require additional information.

Sincerely,

[Physician's Signature]

Click here for the full Prescribing Information, including boxed Warning, and Patient Information.