Date:

Payer Company Name

Street/Building Address

City, State ZIP

ATTN: Contact Name/ Contact Title

Re: Letter of LYVISPAH Medical Necessity for Plan Member Name

*Plan member information:*

Name: First and Last Name

Date of Birth: MM/DD/YYYY

ID Number: Insurance ID Number

Group Number: Insurance Group Number

Dear Sir or Madam:

I understand that your policy regarding coverage for baclofen oral granules (LYVISPAHTM) as a treatment for spasticity resulting from multiple sclerosis, spinal cord injury, and/or other spinal cord diseases requires a “step therapy,” such that a patient needs to fail treatment with a lower-cost generic oral baclofen tablet before you will cover LYVISPAH. In accordance with your policy determination, my patient, who previously had been doing well on oral baclofen tablets, has developed the following problems:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accordingly, I have switched my patient to LYVISPAH and hope that you will now approve this medication without further delay. It is my view that if you do not cover LYVISPAH for patient name, your decision may place him or her at risk for other complications related to inadequate baclofen dosing to treat spasticity, including non-relief of flexor spasms, concomitant pain, clonus, and/or muscular rigidity.

I look forward to hearing of your favorable determination in the case of my patient.

Sincerely,

Signature line