

Checklist for a Letter of Medical Necessity or Letter of Appeal for Alkermes Products

Each insurer determines its own policies, and a prior authorization may sometimes be required for a medication. In some cases, a letter of medical necessity from the physician may be required for a medication to be covered. To support patient access to Alkermes medications, the following checklists are provided to help facilitate communications with health insurance companies to support a prior authorization, a formulary exception request, a medical exception, or an appeal of a denied claim for coverage of an Alkermes medication.

Information you may wish to include in a letter of medical necessity when prescribing an Alkermes product:

- Patient's diagnosis and code, condition, and history
- Previous therapies the patient has taken for the symptoms associated with the disease and the patient's response to previous therapies
- Brief description of the patient's recent symptoms and condition
- Summary of the professional opinion clearly stating the rationale for the treatment recommended for the patient
- Documents that support your rationale for the recommended treatment, including the patient's medical records

Consider reviewing this checklist when your patient is requesting an appeal of a denied insurance claim for an Alkermes product:

- Review the Explanation of Benefits (EOB) to determine the reason for the claim denial
- If additional information is requested, submit it immediately or within the required time frame for processing
- If the denial was due to a technical error, amend it and submit a corrected claim
- Verify the appeals process with the health insurance company
 - Does the health insurance company require use of a specific form?
 - Can the appeal be conducted over the telephone?
 - If the appeal must be submitted in writing, to whom should it be directed?
 - What information must be included with the appeal (eg, a copy of the original claim, EOB, letter of medical necessity, or other documentation)?
 - How long does the appeals process usually take?
 - How will the health insurance company communicate the appeals decision?
- Review the appeal request for accuracy and completeness, including patient identification numbers, coding, and additional information requested
- Consider requesting that the payer have a psychiatrist or other designated provider who is familiar with treating patients with this condition review the appeal
- File the appeal as soon as possible and within filing time limits
- Reconcile responses to the appeal promptly and thoroughly to ensure an appeal has been processed appropriately
- Record appeals result (eg, payment amount or if further action is required)

This is not a guarantee of payment, coverage, or reimbursement. Alkermes does not provide any advice, recommendation, guarantee, or warranty relating to coverage, reimbursement, or coding for any product or service. Healthcare providers are responsible for determining coverage and reimbursement information and ensuring the accuracy and completeness of claim submissions for their patients. Coding, coverage, and reimbursement vary significantly by payer, patient, and setting of care and are subject to change. Additional information may exist. Actual coverage and reimbursement decisions are made by individual payers.