

Date:

Payer Company Name
Street/Building Address
City, State ZIP

ATTN: Contact Name/ Contact Title

Re: Letter of RYTARY 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 carbidopa and levodopa extended-release capsules (RYTARY®) as a treatment for Parkinson’s disease involves a “step therapy,” such that a patient needs to fail treatment with a lower-cost medication before you will cover RYTARY. In accordance with your policy determination, my patient, who previously had been doing well on RYTARY, was switched to insert form of carbidopa/levodopa and did not do well. He/she developed the following problems:

1. _____
2. _____
3. _____

Accordingly, I have switched my patient back to RYTARY and hope that you will now approve this medication without further delay. It is my view that if you do not cover RYTARY for patient name, your decision may place him or her at risk for other complications related to motor fluctuations and other Parkinson’s disease-related motor symptoms.

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

Sincerely,

Signature line