

**Sample Letter of Medical Necessity for GAMMAGARD LIQUID ERC  
[Immune Globulin Infusion (Human)]  $\leq 2 \mu\text{g/mL}$  IgA in a 10% Solution**

[Please print on office letterhead including provider name and address]

[Date]  
[Health plan name]  
[Department]  
ATTN: [Contact title or name]  
[Health plan address]  
[City, State ZIP code]

[Patient's name]  
[Date of birth]  
[Policy number]  
[Case ID number]  
[Date(s) of service]

**Letter of Medical Necessity for GAMMAGARD LIQUID ERC  
[Immune Globulin Infusion (Human)]  $\leq 2 \mu\text{g/mL}$  IgA in a 10% Solution**

Dear [Contact name],

I am writing on behalf of my patient, [patient's name], to request coverage for GAMMAGARD LIQUID ERC for the treatment of primary immunodeficiency (PI) [insert appropriate ICD-10-CM code here]. Based on my clinical judgment, I believe that GAMMAGARD LIQUID ERC is specifically medically necessary for [patient name] because [include brief statement regarding why GAMMAGARD LIQUID ERC is an appropriate treatment for the patient]. This letter provides my clinical rationale along with relevant information about my patient's medical history and treatment.

**Diagnosis and Medical History**

[Patient's name] is [a/an] [age]-year-old [male/female] who has been diagnosed with PI as of [date of diagnosis]. [He/She] has been in my care since [date].

My rationale for prescribing GAMMAGARD LIQUID ERC is based on [include a brief disease course of patient, including history of disease, any symptoms, and previous treatments. Include clinical assessment of patient and side effects and/or response to other treatments].

**Treatment Plan**

In my clinical opinion, [patient's name] should receive GAMMAGARD LIQUID ERC for the following reasons:

[List your recommendations for why GAMMAGARD LIQUID ERC is appropriate for this patient based on diagnosis and medical history. Include documentation of past treatments.]

History of previous therapies	Reason(s) for discontinuation of previous therapies	Duration of previous therapies

I believe treatment with GAMMAGARD LIQUID ERC is the appropriate treatment choice given the history and medical needs of [patient's name]. I have attached relevant [lab test analyses/medical records/clinical studies] to support my decision. Please feel free to contact me at [office phone number] or via email at [physician's email] for any additional information you may require. Thank you for your time and consideration.

Sincerely,  
[Physician's signature]  
[Physician's name]

**Enclosures**

[List enclosures, which may include:

- Medical records
- Laboratory work
- GAMMAGARD LIQUID ERC Prescribing Information
- Other supporting documentation]

SAMPLE