

Date: _____

Contact Name/Department: _____

Insurance Company: _____

Address: _____

City, State, Zip Code: _____

RE: Patient Name: _____

Date of Birth: _____

Policy/Group Number: _____

To Whom It May Concern:

I am writing this letter to support my request to treat my patient [listed above] with Hymovis® One (viscoelastic hyaluronan) given as a single intra-articular injection. I have outlined below my patient's medical history, prognosis, and treatment rationale for your review.

Summary of patient history: [include history, diagnosis, symptoms, previous and current therapies, including response to previous and current therapies]

Proposed treatment plan with Hymovis® One: [include why patient meets approved indication for Hymovis® One and summary of your professional opinion on patient's prognosis/outcome without Hymovis® One]

In summary, I believe it is medically appropriate and necessary to treat this patient with Hymovis® One at this time, and I am requesting its coverage and reimbursement. I have included the package insert for Hymovis® One, which details additional clinical information about this FDA-approved product.

Thank you for your consideration in approving this claim. Please contact me if you require any additional information.

Physician's Name: _____

Physician's Phone Number: _____