Hymovis® HYADD®4 High Molecular Weight Viscoelastic Hyaluronan

Letter of Medical Necessity

Date:		
Contact Name:	Department:	Insurance Company:
Address:	City, State, Zip Code:	
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® (high molecular weight viscoelasatic hyaluronan) injections given at weekly intervals. 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, and response to previous and current therapies):

_____

_____

_____

Proposed treatment plan with HYMOVIS (include why patient meets approved indication for HYMOVIS and summary of your professional opinion on patient's prognosis/outcome without Hymovis):

_____

_____

_____

In summary, I believe it is medically appropriate and necessary to treat this patient with HYMOVIS at this time, and I am requesting its coverage and reimbursement. I have included the package insert for HYMOVIS, 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: _____

www.arthrex.com

Arthrex®