<XX/XX/XXXX>

<Insurance Company Name>

< Insurance Company Street Address>

< Insurance Company City>, < Insurance Company State> < Insurance Company Zip Code>

Re: Letter of Medical Necessity for:

<Patient Name>

<Patient Date of Birth>

<Policy ID#>

<Group#>

Dear Medical Director:

I am writing this letter to serve as formal documentation of the medical necessity of treatment with INBRIJA™ (levodopa inhalation powder) for my patient, <Patient Name>, for <condition for which prescribed>.

I prescribed INBRIJA based on my clinical evaluation of my patient and their medical history. The information below supports my assessment that the use of INBRIJA is both medically appropriate and necessary for my patient.

**Medical History:**

<Patient’s medical history, diagnosis and current conditions>

**Treatment History:**

<Prior treatments and response to those treatments>

It is my clinical opinion that INBRIJA is medically necessary to treat <Patient Name>.

<Summarize basis for professional opinion that Inbrija is medically necessary for the patient>.

If you have any concerns about approving this necessary treatment for my patient, please contact my office at <Office Phone Number> and I will be happy to discuss further.

Sincerely,

<Physician’s name>