**LETTER OF MEDICAL NECESSITY TEMPLATE: S.O.S**

DATE:

TO:

FROM:

PATIENT NAME: DOB:

ICD DIAGNOSIS CODE: Ht: Wt:

MEDICAL FOOD ORDER:

INSURANCE ID:

SUBSCRIBER: GROUP NO:

To Whom It May Concern:

**[Patient name]** is a \_\_\_\_year old patient diagnosed with **[disorder]**, an inborn error of metabolism (**if applicable**). This patient’s metabolic disease was diagnosed through newborn screening **(if applicable**) which is mandated by law in the USA. The purpose of this letter is to explain the medical necessity of Vitaflo S.O.S25and request insurance coverage for this treatment.

**[Disorder]** is an inherited metabolic disease whereby the affected individual is unable to **[describe pathophysiology]**. The accepted standard of care to treat this disorder consists of strict medical nutrition therapy and the use of prescribed medical foods. A characteristic of **[disorder]** is the high risk of developing severe **[list complications]** in times of illness or infection. This leads to an accumulation of toxic metabolites that if left untreated, will lead to **[list/explain problems]** and hospitalization.To prevent such complications, an emergency/sick day regimen is prescribed to maintain metabolic control thus preventing **[note symptoms/problems]** and hospitalization during illness or infection.

**[Patient name]** is currently prescribed S.O.S25, a powdered medical food required as an emergency regimen for **[disease]**. S.O.S25 is medically necessary in preventing medical consequences that occur in situations leading to metabolic crisis. The individually pre-measured packet/dose, ensures that this medical food is administered in the most accurate and reliable manner.

S.O.S25is a powdered medical food which has been prescribed to meet **[name’s]** specific needs tomaintain metabolic control. It is manufactured in the UK for Vitaflo USA, LLC (1-888-848-2356). HCPCS is B4162 & B4157**.** Reimbursement code: 12539-0021-40. Vitaflo S.O.S25 is a medical food that is available ONLY by prescription (not “over the counter”) to be used under strict medical supervision.

**[If applicable include**: In addition, **product name** is on the State of **\_\_\_\_\_\_ Medicaid/BCMH/Metabolic Formulary.]**

I appreciate your consideration of this request. Your authorization of this prescribed order will provide this patient the treatment needed to improve his/her medical situation.

Please feel free to contact me if you have additional questions.

Sincerely,

Name of Physician

Institution

Contact Information

Attachments: Prescription