Date

Re: Patient Name:
Patient Address:
Patient Date of Birth:
Member ID:

To Whom It May Concern:

This letter serves as a request and clinical justification for the above referenced patient to begin treatment with Sovaldi® (sofosbuvir) or Harvoni® (ledipasvir 90mg/sofosbuvir 400mg). The patient exhibits the following signs, symptoms, and/or conditions and would benefit clinically by receiving Sovaldi® or Harvoni®.

[Provide detailed reasons why Sovaldi® or Harvoni® was prescribed including information on patient's condition and previous medications.]

Patient profile:_____
Diagnosis (please specify):_____
Current medications:_____
Patient was previously treated with:_____
_____
Reason for discontinuation or change in therapy:_____
_____
Prescribed Sovaldi® or Harvoni® use:_____

I have enclosed copies of pertinent notes, laboratory, and other test results for your reference. I have also enclosed information on Sovaldi® or Harvoni® and published data regarding clinical utility.

I certify that this information is correct. If you have any questions about this request, please feel free to contact me. I would be more than willing to discuss this specific case with you.

Sincerely,

(MD Info)