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 TRILURON™ (sodium hyaluronate) 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, including response to previous and current therapies]

_____
_____
_____
_____

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

_____
_____
_____

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