TEMPLATE LETTER OF MEDICAL NECESSITY (LMN) FOR PSYCHOTROPIC MEDICATIONS

Must be printed on prescriber's letterhead.
Must be accompanied by a completed Psychotropic Agents for Children/Adolescents Prior Authorization Request (FA-70)

To: Nevada Medicaid

Date: [Current Date]

Re: [Recipient's Name]
[Medicaid ID Number]
[Requested Drug(s)]
[Prescriber's name]
[Prescriber's National Provider Identifier (NPI)]

To Whom It May Concern:

This letter is on behalf of [Recipient Name] who is receiving treatment from me for [Insert Diagnosis(es)]. I believe that treatment with [Requested Drug(s)] is medically necessary because [Insert Treatment Rationale, i.e., how you expect it will benefit the recipient].

I have completed and attached the Prior Authorization Request. I am prescribing this medication(s) [within or outside] the FDA approved guidelines. If treatment is not within the FDA approved guidelines I have attached peer reviewed literature to support this course of treatment.

Please contact me if you need any additional information.

Sincerely,
[Physician's signature]
[Date of signature]
The prescribing physician must sign and date this letter.

TEMPLATE