

**DATE:**

**INSURER NAME:**

**INSURER COMPANY NAME:**

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

Attn: \_\_\_\_\_

**[Name, Department Name]**

RE: Treatment authorization request for \_\_\_\_\_

**[Patient Name]**

**Policy Number** \_\_\_\_\_

**Group Number** \_\_\_\_\_

**Patient ID #** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

To Whom It May Concern:

I am writing on behalf of my patient, \_\_\_\_\_, to document the medical necessity of Axona (caprylidene) therapy.

\_\_\_\_\_’s medical history and treatment pathway are as follows:

- **List previous regimen(s) and outcome(s)**

Axona was launched on March 2, 2009 and is intended for the clinical dietary management of the metabolic processes associated with mild-to-moderate Alzheimer’s disease. Attached is the full prescribing information for Axona. \_\_\_\_\_ should receive Axona for the following reasons:

- **List reasons**

In summary, Axona therapy is necessary and reasonable for \_\_\_\_\_’s medical condition. Please contact me if any additional information is required to ensure the prompt approval of this course of therapy.

Sincerely,

**(Physician Name)**