Disclaimer: Use of this template or the information in this template does not guarantee   
reimbursement for coverage. It is not intended to be a substitute for or to influence the   
independent clinical decision of the prescribing healthcare professional. The completion, accuracy,   
and submission of this form is the sole responsibility of the healthcare provider.

Cover Page for Letter of Medical Necessity for Symbravo®

(meloxicam and rizatriptan)

**The following pages are a template that may be customized to use as a letter of   
medical necessity to be submitted with a Prior Authorization request for SYMBRAVO.**

# To print a copy of the prescribing information, please visit: <https://www.axsome.com/symbravo-prescribing-information.pdf>

<Date>

**ATTENTION:** <Medical Director Name and/or Medical Review/Appeals>

<Payer/Health Plan Name>

<Payer Address>

**REGARDING:** Request for Medical Necessity for Symbravo® (meloxicam and rizatriptan) tablets

**PATIENT NAME:** <Patient Name>

**DATE OF BIRTH:** <Patient Date of Birth>

**POLICY ID NUMBER:** <Patient Policy ID Number>

**PROVIDER ID NUMBER:** <Provider ID Number>

<Optional: Claim rejection number>

Dear <Health Plan Contact Name>:

I am writing this letter of medical necessity in support of my request to treat <Patient Name> with SYMBRAVO for the treatment of <migraine> <migraine without aura> <migraine with aura> <migraine with typical aura> in adults.

As a <board-certified> <Field of Certification> with <##> years caring for patients with acute migraine, I believe that treatment with SYMBRAVO is warranted, appropriate, and medically necessary for this patient based on my clinical judgment and expertise.

The following is the medical history of <Patient Name> and the rationale for treatment with SYMBRAVO. I have also attached to this letter the clinical findings that summarize my patient’s current medical condition and the SYMBRAVO package insert/prescribing information.

|  |  |
| --- | --- |
| **Date of Diagnosis** | <MM/DD/YY> |
| **Diagnosis** | <ICD-10 code> |
| **Summary of clinical symptoms** | * <Patient’s current condition, including an overview of symptoms and quality of life or functional impairment as applicable> * <Test information & results> * <Prognosis without treatment> |
| **Previous and current treatment regimens** | <If applicable, include previous and current pharmacologic treatments for migraine, including drug name, dates of use, and reasons for stopping> |

I would like to prescribe SYMBRAVO for <Patient Name> because I have concluded that it is a medically appropriate and necessary therapeutic option for the following reason(s):

<Rationale for treating the patient with SYMBRAVO. In this rationale, include a description of the patient’s disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

<You may wish to include relevant background or clinical trial information about SYMBRAVO in the letter. For additional information, please refer to the SYMBRAVO Prescribing Information.>

Given the patient’s history, <his/her/their> current condition, and the data of the effects of SYMBRAVO in patients with migraine, I believe that treatment of <Patient Name> with this product is warranted, appropriate, and medically necessary. The totality of the data available to date supports the potential benefit of <treatment/continuing treatment> with SYMBRAVO.

Please feel free to contact me at my office at <telephone number> if I can provide you with any additional information you may require. I look forward to receiving your timely response.

Best regards,

<Physician Signature>

<Physician Name>

<Physician’s NPI>

<Physician Contact Information>

<Phone #>

<Fax #>

**ATTACHMENTS:**

* SYMBRAVO package insert/prescribing information
* Patient clinical notes and other relevant supporting documentation

PP-SYM-US-2500075 05/25