[Your name]
[Your address]
[Your city, state, ZIP]
[Tax ID#]
[Date]

[Name of Rx Plan]
[Address of Rx Plan]

Re: Authorization for DAYVIGO™ (lemborexant) tablets (CIV) use for [patient name]
Member ID:
Group #:
Rx Bin #:
Date of Birth:

To Whom It May Concern:

Please see the enclosed documentation demonstrating the medical necessity for the use of DAYVIGO™ (lemborexant) CIV tablets. My patient, [patient's name], was originally diagnosed with [disorder] in [year of diagnosis]. [Include a description of investigation leading to diagnosis and any treatment that followed the diagnosis.]

At this time, I plan to start [patient name] on course of treatment with DAYVIGO™ tablets.

In my professional opinion, DAYVIGO™ is medically necessary and is an appropriate drug for my patient at this time. Enclosed is the package insert for DAYVIGO™.

My patient is an appropriate candidate for DAYVIGO™, and because the drug is medically necessary, it should qualify for reimbursement under [Patient's name's] benefits. If you require more information, please do not hesitate to contact me.

Please feel free to contact me if you require additional information.

Sincerely,
Physician Name, MD and Signature
cc: [patient's name]