



LETTER OF MEDICAL NECESSITY
FOR DUAL PURPOSE OTC DRUGS AND/OR SUPPLIES

Patient Name: \_\_\_\_\_

University ID Number \_\_\_\_\_

(located on pay advice)

Employee Name: \_\_\_\_\_

Over-the-Counter Drug or Supply Item: \_\_\_\_\_

This form should be completed by the attending physician to confirm the above over-the-counter drug and/or supply item is necessary and recommended to treat a specific medical condition.

1. Describe the diagnosed medical condition being treated. (Include diagnosis code.):

\_\_\_\_\_  
\_\_\_\_\_

2. Describe the recommended treatment:

\_\_\_\_\_  
\_\_\_\_\_

3. Indicate the duration of treatment:

\_\_\_\_\_  
\_\_\_\_\_

This treatment is medically necessary to treat the specific medical condition described above. This treatment and corresponding over-the-counter drug or supply item is not in any way for general health and is not for cosmetic purposes to improve appearance.

Signature of Attending Physician

Date

Print Name

Address

Phone

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.