



**LETTER OF MEDICAL NECESSITY  
FOR DUAL PURPOSE OTC DRUGS**

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

Personnel Number \_\_\_\_\_

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

Over-the-Counter Drug: \_\_\_\_\_

This form should be completed by the attending physician to confirm the above over-the-counter drug 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 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