LETTER OF NECESSITY FOR PELLET THERAPY

Name: _____ Date of Birth: _____

Date: _____ Diagnosis: ICD10 _____

To whom it may concern:

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Pellets are derived from natural plant-based ingredients. They are formulated in specialized 503B compounding pharmacies and possess a similar hormonal structure of the human hormone testosterone. These pellets, once implanted, secrete hormones into the bloodstream constantly.

The dosages are individualized by the physician or practitioner for the patient, taking into consideration their current and past medical history as well as prior experience with other forms of therapy, current medications, etc.

The above patient was seen in my office and was diagnosed with:

Testosterone Deficiency Syndrome ☐ Menopause ☐ Perimenopause ☐

Their lab values indicate androgen and/or estrogen deficiency. Prior to pellet therapy, the patient experienced:

Decreased Libido ☐ Decreased Energy ☐ Mood Swings ☐

Anxiety ☐ GSM Symptoms ☐ Vasomotor Symptoms ☐

Joint Pain ☐ Lethargy and/or ☐ Other _____

Hormone pellet therapy has helped alleviate the above symptoms for this patient and has resulted in an improved quality of life and overall wellbeing. Please honor their request for reimbursement.

Sincerely,

_____

Doctor or Clinic Name