

Sample Format Letter of Medical Necessity

[Insert physician letterhead]

[Medical Director]

[Insurance Company]

[Address]

[City, State, Zip]

RE: Patient Name _____

Policy Number _____

Claim Number _____

Dear:

I am writing to provide additional information to support my claim for the treatment of **[insert patient name]** with STELARA™ (ustekinumab) for **[insert diagnosis]**. In brief, treatment of **[insert patient name]** with STELARA™ is medically appropriate and necessary and should be a covered and reimbursed service. Below, this letter outlines **[insert patient name]**'s medical history, prognosis, and treatment rationale.

Summary of Patient History [You may want to include]:

[Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient's medical condition.]

- **Patient's diagnosis, condition, and history**
- **Previous therapies the patient has undergone for the symptoms associated with psoriasis**
- **Patient's response to these therapies**
- **Brief description of the patient's recent symptoms and conditions**
- **Summary of your professional opinion of the patient's likely prognosis or disease progression without treatment with STELARA™**

Rationale for Treatment

Given the patient's history, condition, and the published data supporting use of STELARA™, I believe treatment of **[insert patient name]** with STELARA™ is warranted, appropriate, and medically necessary. The attached copies of clinical peer-reviewed published literature and package insert document that STELARA™ is an effective therapy for patients like **[insert patient name]**.

Please call my office at **[insert telephone number]** if I can provide you with any additional information. I look forward to receiving your timely response and approval of this claim.

Sincerely,

[Insert Doctor name and participating provider number]

Enclosures