## Sample letter: Appealing a switch to biologics on behalf of a patient

This letter is only an example.
Please edit this letter to suit your patient’s needs and replace **bolded** sections with the appropriate information. Remove this portion before submitting to your patient’s insurance company.

[**Today’s date**]

[**Name of Medical Director**]
[**Name of Insurance Company**]
[**Mailing address of Insurance Company**]
Re: [**Patient name**]
[**Member Identification number**]
[**Date of birth**]

Dear [**Name of Medical Director**],

I am contacting you on behalf of my patient, [**patient name (insurance ID #)**], to switch to a biologic treatment. [**Patient name**] is under my care for [**his/her**] [**psoriasis and/or psoriatic arthritis**] [**ICD code(s)**]. [**He/She**] has [**number**] percent of body surface area affected by psoriasis. [**Psoriasis is also involved in sensitive areas including face/genitals**]. This categorizes [**his/her**] psoriasis as [**moderate/severe**]. [**Patient name**] has [**number**] of joint or sites affected by psoriatic arthritis and can be categorized as [**moderate/severe**]. [**Patient name**] started with [**treatment name/dose**] in [**year**]**.** [**Include any other treatments the patient has tried**]. Previous treatments have been unsuccessful due to [**list reasons**]**.**

[**Explain how psoriasis affects patient’s personal or social life, work or ability to work, emotional well-being, or other aspects**].

[**Explain any comorbidities that patient has that is linked to psoriasis or psoriatic arthritis, such as heart disease, stroke, high blood pressure, diabetes, depression, or others**].

In view of [**name of patient**]’s signs, symptoms, and history, I feel that [**he/she**] is no longer a candidate for [**name of previous treatment/medicine**]. It is not unusual for patients to cycle through different treatments for their psoriasis as medicines work differently for different people and may also lose its effectiveness over time.

I believe that [**name of recommended treatment/medicine**] is medically necessary. [**Insert rationale for prescribing treatment/medicine here, including your professional opinion of the patient’s likely benefit from treatment or disease progression without treatment. Include review of patient’s treatment history of treatment failure and contraindications to other treatments. Explain patient qualifications for pre-authorization requirements if possible or why an exception should be granted**].

Please feel free to contact me, [**physician name**], at [**office phone number**] or [**patient’s name**] at [**patient phone number**] for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

[**Physician name and signature**]
[**Physician medical specialty**]
[**Physician NPI**]
[**Physician practice name**]
[**Physician office mailing address**]
[**Physician phone number**]
[**Physician fax number**]

[**Patient name and signature]**

Encl: Medical records
Supporting documentation
Photo(s)
Letter of Medical Necessity (LMN)

CC:   [**Name of patient**]