Sample Letter of Medical Necessity for ENTYVIO

[Physician's letterhead]

[Date]
[Health plan's name]
ATTN: [Department]
[Medical director's name]
[Health plan's address]
[City, State ZIP]

[Patient's name]
[Date of birth]
[Case ID number]
[Date(s) of service]

Re: Letter of Medical Necessity for ENTYVIO® (vedolizumab)

Dear [Medical director's name],

I am writing this letter on behalf of my patient, [patient's name], to request coverage for ENTYVIO for the [intravenous/subcutaneous] treatment of moderately to severely active [Crohn's disease (CD)/ulcerative colitis (UC)] ([insert appropriate ICD-10-CM code here]). I have read and acknowledged your drug coverage policy and [include brief statement regarding opinion why ENTYVIO is an appropriate treatment for the patient]. This letter provides my clinical rationale along with relevant information about my patient's medical history and treatment.

Patient's diagnosis and medical history
[Patient's name] is [a/an] [age]-year-old [male/female] who has been diagnosed with [CD/UC]as of [date of diagnosis]. [He/she] has been in my care since [date].

My rationale for prescribing ENTYVIO is based on [include a brief disease course of patient, including history of disease, any symptoms, and previous treatments such as completion of ENTYVIO IV doses if CD/UC patient is transitioning to the ENTYVIO Pen. Include clinical assessment of patient, response to treatment with ENTYVIO, side effects and/or response to other CD/UC treatments].

Treatment plan
In my clinical opinion, [patient's name] should receive ENTYVIO for the following reasons:

[List your recommendations for why ENTYVIO is appropriate for this patient based on diagnosis and medical history. Include documentation of past treatments.]

History of previous therapies	Reason(s) for discontinuation of previous therapies	Duration of previous therapies

I have reviewed your formulary for [CD/UC] and [summarize why the preferred drugs on formulary are not sufficient for your patient at this time].

Summary

I believe [insert reason for belief that treatment with ENTYVIO is appropriate]. I have attached relevant [lab test analyses/medical records/clinical studies] to support my decision. If you have any further questions about this matter, please contact me at [physician's phone number] or via email at [physician's email]. Thank you for your time and consideration.

Sincerely,

[Physician's signature]

Enclosures

[List and attach enclosures, which may include:

- Medical records
- Laboratory work
- ENTYVIO Prescribing Information
- Other supporting documentation]