

## Sample Letter of Appeal for ENTYVIO (prior authorization/general appeal)

[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: Appeal of Denial for ENTYVIO® (vedolizumab)

Dear [Medical director's name],

I am writing to request reconsideration of your denial of coverage for [ENTYVIO intravenous (IV) infusions/ENTYVIO Pen for subcutaneous (SC) injection (**Template note: the Pen is for UC diagnosis only**)] which I have prescribed for [patient's name]. I have read and acknowledged your policy for responsible management of drugs for moderately to severely active [Crohn's disease (CD)/ulcerative colitis (UC)] [insert appropriate ICD-10-CM code here]. Your reason(s) for the denial [is/are] [reason(s) for the denial].

Based on my medical care provided for this patient, I believe [insert reason for belief that treatment with ENTYVIO [IV/Pen] is medically necessary. If the denial is for the ENTYVIO Pen and the patient has been stable on ENTYVIO IV, affirm clinical response or remission to ENTYVIO IV].

### Patient diagnosis and medical history in support of the appeal

[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].

[Include relevant medical information to support your reason for treatment with ENTYVIO. Include history of treatment. If patient is transitioning to ENTYVIO Pen for SC injection, include history of treatment on ENTYVIO IV.]

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

[Additional information needed may include:

- Supporting documentation as requested by the plan in their denial letter
- Discussion of clinical attributes of ENTYVIO and relevance to your patient
- Your assessment of why ENTYVIO is appropriate for this patient based on medical evidence]

### **Summary**

This is my [level of request] prior authorization appeal. A copy of the [level of denial] denial letter is included along with my medical notes in response to the denial. In my professional opinion and considering [patient's name]'s history and condition, I believe [insert reason for belief that treatment with ENTYVIO is appropriate]. 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 enclosures, which may include:

- Explanation of benefits/denial letter
- Copies of original claim form
- Letter of Medical Necessity
- Clinical notes/diagnostic pathology report
- Medication records
- Relevant laboratory reports
- ENTYVIO Prescribing Information
- Other supporting documentation]