

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 (**Template note: the Pen is for UC diagnosis only**) 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 believe that ENTYVIO is the appropriate treatment for my patient at this time. 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 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]