[Date]

[Insurance Company Name]
[Attn: Appeals/Medical Review Department]
[Insurance Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity for [Patient Name]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Policy ID]
Group Number: [Group ID]
Claim/Reference Number: [Reference Number if applicable]

To Whom It May Concern,

I am writing to request authorization for **[Name of Biologic Medication]** for the treatment of **[Patient Name]**, who is under my care for **Moderate to Severe Rheumatoid Arthritis (ICD-10 Code: M06.9)**. Based on the patient's clinical history and disease progression, I have determined that this medication is medically necessary.

Clinical History and Diagnosis:
The patient was diagnosed with Rheumatoid Arthritis on [Date]. Current clinical markers include [mention high CRP/ESR levels, positive RF/anti-CCP, or joint erosions on imaging]. The patient currently presents with [mention number of swollen/tender joints, morning stiffness, or functional limitations].

Previous Treatments and Failures:
The patient has attempted the following treatments without achieving adequate disease control or due to intolerable side effects:

- **[DMARD Name, e.g., Methotrexate]:** Used from [Dates] to [Dates]. Reason for discontinuation: [e.g., Inadequate response/Hepatotoxicity].
- **[DMARD Name, e.g., Sulfasalazine]:** Used from [Dates] to [Dates]. Reason for discontinuation: [e.g., GI intolerance].
- **[Previous Biologic, if applicable]:** Used from [Dates] to [Dates]. Reason for discontinuation: [e.g., Secondary failure].

Medical Justification:
Because the patient has failed conventional synthetic DMARDs, initiating **[Name of Biologic Medication]** is the next appropriate step according to ACR (American College of Rheumatology) guidelines. Delaying this targeted therapy increases the risk of irreversible joint damage, permanent disability, and systemic complications.

I request that you approve the coverage for **[Name of Biologic Medication]** to ensure the best possible outcome for my patient. Please contact my office at **[Phone Number]** if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice Name]
[NPI Number]