

Date: [Date]

To: [Insurance Company Name]

Attention: [Prior Authorization/Appeals Department]

Fax/Address: [Fax Number or Address]

RE: Letter of Medical Necessity for [Patient Name]

Patient Date of Birth: [DOB]

Member ID: [ID Number]

Group Number: [Group Number]

Case Number: [Case Reference Number, if applicable]

Dear Medical Director,

I am writing to request approval for [Name of Monoclonal Antibody Drug] for the treatment of [Patient Name], who is under my care for **Severe Plaque Psoriasis (ICD-10: L40.0)**.

Clinical Documentation:

The patient presents with severe plaque psoriasis involving [Percentage]% of their Total Body Surface Area (BSA). Areas affected include [list sensitive areas, e.g., face, hands, feet, or genitals], significantly impacting their activities of daily living and quality of life.

Treatment History:

The patient has previously attempted and failed the following therapies due to lack of efficacy or intolerable side effects:

- [Drug Name 1]: [Dates used], [Reason for discontinuation]
- [Drug Name 2]: [Dates used], [Reason for discontinuation]
- [Drug Name 3 (e.g., Methotrexate/Phototherapy)]: [Dates used], [Reason for discontinuation]

Rationale for Treatment:

Based on the patient's disease severity and failure of conventional systemic therapies, I have determined that [Name of Monoclonal Antibody Drug] is medically necessary. This medication targets [Specific Pathway, e.g., IL-17, IL-23, or TNF-alpha] and is the most appropriate clinical intervention to prevent further disease progression and long-term complications.

I have attached [clinical notes, pathology reports, and photographs] to support this request. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Name, MD/DO]

[NPI Number]

[Practice Name]