Date: [Date]

TO: [Insurance Company Name]
ATTN: [Appeals/Medical Review Department]
FAX: [Insurance Fax Number]

RE: [Patient Name]
DOB: [Patient Date of Birth]
Member ID: [Member ID Number]
Group Number: [Group Number]
Case Number: [Case Reference Number, if applicable]

Dear Medical Director,

I am writing to request authorization and provide a Letter of Medical Necessity for **[Name of Biologic Medication]** for the treatment of my patient, **[Patient Name]**, who has been diagnosed with moderate-to-severe Crohn's Disease (ICD-10: K50.x).

Clinical History and Diagnosis:
The patient was diagnosed with Crohn's Disease on [Date of Diagnosis]. The disease is currently located in the [Location, e.g., terminal ileum/colon] and is characterized by [Symptoms, e.g., chronic diarrhea, abdominal pain, weight loss, fistulas]. Recent [Endoscopy/Imaging] performed on [Date] showed [Findings, e.g., deep ulcerations, strictures].

Previous Therapies Attempted:
The patient has failed the following treatments or has contraindications to them:

- [Drug Name, e.g., Mesalamine]: [Dates/Duration] - Reason for failure: [Inadequate response/Intolerance]
- [Drug Name, e.g., Azathioprine]: [Dates/Duration] - Reason for failure: [Side effects/Lack of efficacy]
- [Drug Name, e.g., Corticosteroids]: [Dates/Duration] - Reason for failure: [Steroid dependency/Refractory]
- [Previous Biologics, if any]: [Dates/Duration] - Reason for failure: [Primary non-response/Secondary loss of response]

Rationale for Treatment:
Based on the patient's disease severity and history of failed conventional therapies, **[Name of Biologic Medication]** is medically necessary to achieve clinical remission, prevent bowel damage, and avoid surgical intervention. [Add any specific trial data or patient-specific factors such as extraintestinal manifestations].

I request that you approve coverage for **[Name of Biologic Medication]** at a dose of [Dose and Frequency]. Please contact my office at [Phone Number] if further information is required.

Sincerely,

[Physician Name, MD/DO]
[Gastroenterology Practice Name]
[NPI Number]
[Phone Number]