

Date: [Insert Date]

To: [Insurance Company Name]

Attention: Prior Authorization/Appeals Department

Address: [Insert Address]

Re: Letter of Medical Necessity for [Patient Name]

Date of Birth: [Insert DOB]

Member ID: [Insert ID Number]

Group Number: [Insert Group Number]

Dear Medical Director,

I am writing to request coverage for [**Name of Medication**] for my patient, [Patient Name], who is under my care for **Chronic Moderate-to-Severe Atopic Dermatitis (ICD-10: L20.x)**.

Patient Clinical History:

The patient has a documented history of severe atopic dermatitis involving [Percentage]% of their Body Surface Area (BSA). Their condition significantly impacts activities of daily living and is characterized by [mention symptoms: e.g., intractable pruritus, skin weeping, sleep deprivation, or lichenification].

Previous Failed Therapies:

The patient has failed to achieve adequate clinical response or has contraindications to the following standard treatments:

- **Topical Corticosteroids (High Potency):** [List names/dates used] - Result: [Failed/Inadequate response]
- **Topical Calcineurin Inhibitors:** [List names/dates used] - Result: [Failed/Inadequate response]
- **Systemic Immunosuppressants/Phototherapy:** [List treatments such as Methotrexate, Cyclosporine, or UV therapy] - Result: [Failed/Side effects]

Clinical Rationale:

Based on the patient's current Eczema Area and Severity Index (EASI) score of [Insert Score] and the failure of conventional therapies, I have determined that [**Name of Medication**] is medically necessary. This specialty medication is the most appropriate next step to achieve disease control and prevent further complications or hospitalizations.

I request that you approve this treatment immediately. Please contact my office at [Phone Number] if you require further clinical documentation.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[NPI Number]
[Practice Name]