[Physician Name]
[Practice/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

[Insurance Company Name]
[Appeals Department Address]
[City, State, Zip Code]

RE: Letter of Medical Necessity / Appeal for [Patient Name]
Patient Date of Birth: [DOB]
Member ID: [ID Number]
Claim/Reference Number: [Reference Number]

To Whom It May Concern,

I am writing to formally appeal the denial of coverage for **[Name of Biologic Medication]** for my patient, **[Patient Name]**. I am requesting an expedited review of this request as this treatment is medically necessary for the management of the patient's **[Diagnosis/Condition, e.g., Crohn's Disease, Rheumatoid Arthritis]** (ICD-10 code: [Code]).

Clinical History:
The patient has been under my care since [Date]. Their condition is characterized by [List symptoms and severity]. Despite standard therapies, the patient continues to experience [Specific issues, e.g., active flares, joint destruction, loss of function].

Previous Treatments/Step Therapy:
The patient has previously failed or has contraindications to the following preferred formulary agents:

- [Drug Name 1]: Used for [Duration]. Outcome: [Reason for failure/Side effects].
- [Drug Name 2]: Used for [Duration]. Outcome: [Reason for failure/Side effects].

Rationale for Biologic Therapy:
Based on [Patient's Name]'s clinical presentation and the failure of alternative treatments, **[Name of Biologic Medication]** is the most appropriate next step in therapy. Clinical evidence suggests that this specific biologic mechanism is necessary to achieve [Clinical Goal, e.g., remission, prevention of permanent disability]. Delaying this treatment puts the patient at significant risk for [List complications].

Included with this letter are [List supporting documents, e.g., lab results, imaging reports, clinical notes] which further substantiate the medical necessity of this request.

I urge you to overturn the initial denial and authorize the use of **[Name of Biologic Medication]** immediately. Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[NPI Number]