**Sample Letter of Appeal for Entyvio**

[Physician’s letterhead]

[Date] [Patient’s name]

[Health plan’s name] [Date of birth]

ATTN: [Department] [Case ID number]

[Medical director’s name] [Dates of service]

[Health plan’s address]

[City, State ZIP]

Re: Appeal of Denial for Entyvio® (vedolizumab)

Dear [Medical director’s name],

I am writing to request reconsideration of your denial of coverage for Entyvio, which I have prescribed for [patient’s name]. I have read and acknowledged your policy for responsible management of drugs for [Crohn's disease (CD)/ulcerative colitis (UC)] [insert appropriate ICD-10-CM code here]. Your reason(s) for the denial [is/are] [reason(s) for the denial].

Based on the patient’s condition and medical history, as well as my experience treating patients with [CD/UC], I believe treatment with Entyvio is warranted, appropriate, and medically necessary in this case. Please see my clinical reasoning below.

**Patient diagnosis and medical history in support of the appeal**

[Patient’s name] is [a/an] [age]-year-old [male/female] patient who has been diagnosed with [CD/UC] as of [date of diagnosis]. [He/she] has been in my care since [date].

[Include relevant medical information to support your reason for treatment with Entyvio. An example may include evidence that the patient’s symptoms and disease activity have been progressing despite treatments with a tumor necrosis factor (TNF) blocker, immunomodulators, or corticosteroids. Additional information needed may include:

* Supporting documentation as requested by the plan in their denial letter
* Discussion of clinical attributes of Entyvio and relevance to the patient
* Review of previous therapy
* Your recommendations for why Entyvio is appropriate for this patient]

**Summary**

This is my [level of request] prior authorization appeal. A copy of the [level of denial] denial letter is included along with my medical notes in response to the denial. In my professional opinion and considering [patient’s name]’s history and condition, I believe treatment with Entyvio is appropriate and medically necessary. If you have any further questions about this matter, please contact me at [physician’s phone number] or via e-mail at [physician’s e-mail]. Thank you for your time and consideration.

Sincerely,

[Physician’s signature]

**Enclosures**

[List enclosures, which may include: the explanation of benefits/denial letter, copies of original claim form, Letter of Medical Necessity, clinical notes/diagnostic pathology report, medication records, relevant laboratory reports that support the need for Entyvio, Entyvio Prescribing Information, and other supporting documentation.]

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