[Date]
[Appeals department]
[Name of health plan]
[Mailing address]

RE: [Patient name]
Policy number: [Policy number]
Treatment requested: ILUMYA™ (tildrakizumab-asmn)

This letter is sent on behalf of [patient's name] to request an appeal of a denied prior authorization for ILUMYA™. According to the denial letter, [name of health plan] denied this prior authorization because [reason from denial letter]. I am asking that you reconsider your denial of coverage for ILUMYA™ for the treatment of moderate to severe plaque psoriasis [ICD-10 code] for [patient's name].

ILUMYA™ [dose, frequency] is the appropriate therapy for [patient's name]. [Patient's name] has moderate to severe plaque psoriasis on [X]% of [his/her] body. [Provide a brief summary of current condition, past treatments, contraindications to other therapies, and any sensitive areas involved.]

Enclosed you will find additional documentation with relevant clinical history for [patient's name], including diagnosis, current condition, and symptoms. Using ILUMYA™ for my patient is based on [provide a clinical rationale for the use of ILUMYA™ in this clinical case].

[Indicate here if the patient has active tuberculosis or other serious infections (required by some health plans).] I am attesting that my patient [does/does not] have active tuberculosis or other serious infections.

[If the patient has any serious infections, please list them.]

Please contact my office by calling [phone number] for any additional information you may require in support of this appeal. I look forward to your timely approval.

Sincerely,
[Physician signature]
[Insert name]

Suggested enclosures:
Copy of denial letter
Package insert for ILUMYA™
Medication records
Scoring forms and photos of affected areas
Clinical records that support the need for ILUMYA™
Other supporting documentation

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