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

RE: [Patient name]
Policy number: [Policy number]
Claim number: [Claim number]
Subject: Supporting Coverage of ILUMYA™ (tildrakizumab-asmn)

Dear [Medical director],

This letter is sent on behalf of [patient's name] to document that [he/she] has been diagnosed with moderate to severe plaque psoriasis and requires treatment with ILUMYA™. I am writing to document my patient's medical history and diagnosis and summarize my treatment rationale. Treatment with ILUMYA™ [dose, frequency] is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old [male/female] who was diagnosed with moderate to severe plaque psoriasis on [date]. [Patient's name] has been in my care since [date] and has moderate to severe plaque psoriasis on [X]% of [his/her] body. [List any sensitive body surface areas involved and symptoms.]

[Provide any other information that in your professional medical judgment is relevant, including but not limited to a brief summary of patient's history and current condition, including any previous treatments, contraindications to other treatments, and what factors led you to recommend the use of ILUMYA™.]

[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 below.]

ILUMYA™ [was/will be] prescribed to [patient's name] for the treatment of moderate to severe plaque psoriasis. Enclosed you will find other relevant supporting documentation.

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

Sincerely,
[Physician signature]
[Insert name]

Suggested enclosures:
Package insert for ILUMYA™
Copy of patient medical records
Scoring forms and photos of affected areas
Other supporting documentation

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