[Insert Physician Letterhead]

[Insert Name of Medical Director] Re: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State ZIP]

Dear [Insurance Company Contact]:

I am writing to request a reconsideration of my request for the treatment of [insert patient name]with TREMFYA® (guselkumab). In brief, treatment with TREMFYA® 100 mg is medically appropriate and necessary and should be a covered treatment. This letter outlines [insert patient name]’s medical history, prognosis, and treatment rationale.

[Insert plan name]has denied coverage of TREMFYA® for [insert patient’s name]because [insert reason for denial   
as indicated on the explanation of benefits].The following rationale supports my decision to prescribe TREMFYA®:

In my judgment, [Product X]is not a medically appropriate treatment for [insert patient name]because he/she has   
[insert rationale, eg, personal medical history/family history, contraindication, comorbid condition, prior inadequate response, or adverse reaction to Product X].

**Summary of Patient’s History and Diagnosis**

[Insert summary of patient history and diagnosis per your medical judgment.

You may want to include:

* Document that patient does not have active tuberculosis
* Percentage of body surface area (BSA) currently affected, IGA and/or PASI severity scores
* Description of patient’s recent symptoms/condition, including photographs of plaques/location of   
  plaques if applicable
* Previous treatment of plaque psoriasis (including TREMFYA® if applicable) and patient’s response
* Number of swollen and/or tender joints if applicable
* Number of tender or painful areas other than joints (enthesitis); number of entire fingers or toes  
  swollen (dactylitis) if applicable
* Patient assessment of pain, patient global assessment, physician global assessment, if applicable
* Functional status, ie, Health Assessment Questionnaire Disability Index (HAQ-DI), if applicable
* Lab test results and applicable dates
* Patient co-morbidities that could serve as contraindications to certain other treatments if applicable
* Prior therapies/procedures for psoriatic arthritis (including TREMFYA® if applicable) and responses to those treatments
* Site of medical service—include appropriate one and provide rationale: Physician-supervised administration  
  or self-administration, eg, compliance, needle phobia, closely monitoring patients
* Summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment  
  with TREMFYA®

Note: exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s  
medical condition.]

**Rationale for Treatment**

Given the patient’s history, condition, and the published data supporting use of TREMFYA®, treatment of [insert patient   
name]with TREMFYA® is warranted, appropriate, and medically necessary.

The attached copies of [clinical peer-reviewed literature, clinical guidelines, full Prescribing Information, photographs of plaques/location of plaques if applicable]document that TREMFYA® is an appropriate treatment option for this patient.   
If you disagree with coverage and uphold this denial, I am requesting that a [dermatologist/rheumatologist] review   
this documentation.

I look forward to receiving your timely response and reconsideration of this request.

Sincerely,

[Insert healthcare provider’s name, contact information, and participating provider number]

Enclosures [Include full Prescribing Information and the additional support noted above]