Insert logo/header here

Patient:

DOB:

Patient ID#:

Drug:

ICD10Code:

ATTN:

P.O. Box 00000

Santa Ana, CA 92799

Fax: 1-877-289-0000

To Whom It May Concern:

I am writing to appeal the denial of Cosentyx on behalf of my patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_. \_\_\_\_\_\_\_\_\_\_\_\_is a \_\_\_-year-old\_\_\_\_\_\_\_ under my care for the treatment of his/her \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.  I have attached the step therapy legislation for North Carolina (Web address: <https://www.ncleg.gov/Sessions/2019/Bills/Senate/PDF/S361v8.pdf>) as well as clinical documentation to be reviewed.  Patient has a \_\_\_\_\_\_\_\_\_\_risk/reaction and it is medically necessary for her to start \_\_\_\_\_\_\_\_\_\_\_.

As a specialized clinician who is familiar with \_\_\_\_\_\_\_\_\_\_\_ disease characteristics, as well as his/her complete clinical picture, I am confident the on-label use of \_\_\_\_\_\_\_\_ for my patient is warranted, appropriate, and medically necessary. The decision to disallow this therapy denies her the multiple benefits of a proven highly efficacious treatment. Please review this case, reconsider this treatment decision, and approve \_\_\_\_\_\_\_\_\_\_\_for \_\_\_\_\_\_\_\_\_\_\_\_.

Thank you for your consideration of this matter. If you have any questions or concerns, please feel free to contact me.

Sincerely,