**[Insert onto physician letterhead]**

**[Medical Director] RE: Patient Name**

**[Insurance Company] Policy Number**

**[Address] Claim Number**

**[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) for moderate to severe plaque psoriasis. In brief, treatment with TREMFYA® 100 mg at weeks 0 and 4, and every 8 weeks thereafter 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 of/family history of X condition, contraindication, comorbid   
condition, prior inadequate response, or adverse reaction to Product X].**

**Summary of Patient’s History and Treatment Rationale. [Insert summary of patient history and diagnosis per   
your medical judgment].**

**You may want to include:**

* **Patient’s relevant history, findings, and diagnosis**
* **Previous treatment of plaque psoriasis including TREMFYA®, if applicable**
* **Patient’s response to these therapies including TREMFYA®, if applicable**
* **Brief description of the patient’s recent symptoms and conditions including photographs of plaques/   
  location of plaques**
* **Site of medical service—select 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 without treatment with TREMFYA®**

**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, full Prescribing Information, photographs of plaques/   
location of plaques]** 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 review this documentation.

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

Sincerely,

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

**Enclosures**