**[Physician’s Letterhead]**

**[Insert Date]**

ATTN: **[Medical Review/Appeals] [Payer Name] [Payer Address]**

Patient: **[Patient’s first and last name]**

Subscriber ID #: Subscriber Group #:

RE: Entyvio® (vedolizumab) claim denial

Dates of Service: **[include all denied dates of service]**

Dear Appeal Reviewer:

On behalf of my patient, **[patient name]**, I am writing this letter to request reconsideration of a denied claim for the administration of Entyvio injection on **[date of service]**. According to the explanation of benefits (EOB), **[name of insurer/Medicare contractor]** denied this claim because **[insert reason for denial as listed on the EOB]**. This letter serves to request a formal appeal of denied claim **[insert claim number]** for **[patient name]**, with policy number **[insert policy number]**.

**[Insert appropriate indication for your patient’s condition/diagnosis; see below]**

**INDICATIONS: ENTYVIO® (vedolizumab) Adult Ulcerative Colitis (UC)**

Adult patients with moderately to severely active UC who have had an inadequate response with,

lost response to, or were intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:

 inducing and maintaining clinical response

 inducing and maintaining clinical remission

 improving endoscopic appearance of the mucosa

 achieving corticosteroid-free remission

**Adult Crohn's Disease (CD)**

Adult patients with moderately to severely active CD who have had an inadequate response with, lost response to, or were intolerant to a TNF blocker or immunomodulator; or had an inadequate response with, were intolerant to, or demonstrated dependence on corticosteroids:

 achieving clinical response

 achieving clinical remission

 achieving corticosteroid-free remission

In conclusion, using Entyvio for **[patient name]** is based on **[provide rationale for the use of Entyvio in this clinical case]**. Enclosed is additional information, including **[list relevant documentation]**, that supports this treatment decision and establishes the clinical need for Entyvio. I have prescribed the use of Entyvio as a medically necessary part of my patient’s treatment plan. Please contact me at **[physician telephone number]** if you require additional information.

Thank you in advance for your immediate attention to this request.

Sincerely,

**[Physician’s Signature]**, MD

**[Insert Doctor Name, participating provider number, and phone number]**

Enclosures: (suggested)

Explanation of Benefits/Denial Letter

Copies of original claim form

Entyvio® (vedolizumab) package insert Clinical notes/diagnostic pathology report Medication records

Relevant laboratory reports that support the need for Entyvio

Other supporting documentation