**[Physician’s Stationery] [Insert Date]**

**[Medical Director] [Insurance Company] [Address]**

**[City, State ZIP]**

RE: Patient Name: **[Insert Patient Name]** Policy Number: **[Insert Policy Number]** Claim Number: **[Insert Claim Number]**

Subject: Supporting Coverage of Entyvio® (vedolizumab)

Dear **[Insert Medical Director’s Name]**:

On behalf of my patient, **[patient name]**, I am writing this letter to document the medical necessity of administering Entyvio. **[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

This letter serves to document my patient’s medical history and diagnosis, summarize my treatment rationale, and also provide a copy of the Prescribing Information for Entyvio.

**[Name of patient]** is a **[age]**-year-old **[male/female]** who was initially diagnosed with **[condition]** on **[mm-dd-yyyy]** by **[Dr. XYZ]** at **[facility ABC]**. **[Name of patient]** has been in **[my or treating physician’s name]** care since **[date]**.

**[Provide a brief discussion of patient’s history and current condition, laboratory results, and previous treatments, highlighting those factors leading you to recommend the use of Entyvio]**.

Entyvio **[was/will be]** administered to **[patient name]** for the treatment of **[his/her condition]**.

In summary, treatment with Entyvio is medically necessary for this patient, as outlined above, based on clinical facts and other enclosed supporting documentation. Because of this, I expect that your coverage for the cost of Entyvio would be appropriate, and I am confident you will agree. Please contact me at **[physician’s telephone number]** if I can provide additional information about this case.

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)

Entyvio® (vedolizumab) package insert

Statement of medical necessity form

Other supporting documentation