Submitting a letter of medical necessity

You may need to provide a letter of medical necessity (LMN) if:

- Your patient's claim was denied and you are submitting an appeal letter
- You are requesting a formulary exception or tiering exception to get access for your patient

Make sure you have the following for an efficient submission of your letter of medical necessity:

- Patient's insurance policy/ID number
- Case ID number if a decision has already been rendered
- Patient's full name, plan identification number, and date of birth
- A brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)
- Clinical support for your recommendation
- Your office contact information

For support in person or over the phone, call your Access Specialist at 1.877.COMPLETE (1.877.266.7538).

Please see Indication and Important Safety Information on page 3.

Please see full Prescribing Information at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

Skyrizi™ COMPLETE

Skyrizi™
risankizumab-rzaa
75mg/0.83mL Injection

Sample letter of medical necessity

Ask the payer whether a specific form is required to help establish medical necessity.

Follow up with the payer if your office does not receive notification of the decision in a timely manner.

[Date]
[Payer Name]
[Payer Address]
Attn: [Appeals Department]
Re: [Patient Name]
[Policy ID/Group Number]
[Date of Service]

To whom it may concern:

My name is [name] and I am a [board-certified medical specialty] [NPI] writing on behalf of my patient, [patient name], to request coverage for [product, dosage, and frequency]. [Patient Name] has been under my care for [X months] for the treatment of [disease or symptoms].

I am writing this letter for medical necessity because after working with [Patient name], I believe that [product name] is the best treatment for this patient, and it's important that a formulary exception be made.

[Provide a brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)].

[Discuss rationale for using <product name> vs other treatments. Insert your recommendation summary here, including your professional opinion of your patient's likely prognosis or disease progression without treatment.].

[List of pertinent medical records] are enclosed, which offer additional support for the formulary exception request for [product name]. Please consider coverage of [product name] for my patient.

Please contact me at [telephone number] to answer any pending questions. I would be pleased to speak to the medical necessity of [product name] for [patient's name]'s [diagnosis].

Thank you in advance for your attention to this request.

Sincerely,

[Physician Name]
[Physician's medical specialty]
[Physician's NPI]
[Physician's practice name]
[Phone #]
[Fax #]

This information is presented for informational purposes only and is not intended to provide reimbursement or legal advice. Providers are encouraged to contact third-party payers for specific information about their coverage policies. For more information, please call an Access Specialist at 1.877.COMPLETE (1.877.266.7538).

Digital version available at CompletePro.com and SkyriziHCP.com.

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Indication and Important Safety Information for SKYRIZI

Indication[1]

SKYRIZI™ (risankizumab-rzaa) is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Important Safety Information[1]

Infection

SKYRIZI™ (risankizumab-rzaa) may increase the risk of infection. Do not initiate treatment with SKYRIZI in patients with a clinically important active infection until it resolves or is adequately treated.

In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing SKYRIZI. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If a patient develops such an infection or is not responding to standard therapy, closely monitor and discontinue SKYRIZI until the infection resolves.

Pre-Treatment Evaluation for Tuberculosis (TB)

Prior to initiating treatment with SKYRIZI, evaluate for TB infection and consider treatment in patients with latent or active TB for whom an adequate course of treatment cannot be confirmed. Monitor patients for signs and symptoms of active TB during and after SKYRIZI treatment. Do not administer SKYRIZI to patients with active TB.

Immunizations

Prior to initiating SKYRIZI, consider completion of all age appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with SKYRIZI.

Adverse Reactions

Most common (≥1%) adverse reactions associated with SKYRIZI include upper respiratory infections, headache, fatigue, injection site reactions, and tinea infections.

Reference: 1. SKYRIZI [package insert]. North Chicago, IL: AbbVie Inc.

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