**Sample Format Letter of Medical Necessity**

**[Insert physician letterhead]**

[Medical Director] RE: Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Insurance Company] Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Address] Claim Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[City, State, ZIP]

Dear:

I am writing to provide additional information to support my claim for the treatment of

**[insert patient name]** with STELARA® (ustekinumab) for **[insert diagnosis]**. In brief,

treatment of **[insert patient name]** with STELARA® is medically appropriate and

necessary and should be a covered treatment. Below, this letter outlines **[insert patient**

**name]**’s medical history, prognoses, and treatment rationale.

**Summary of Patient’s History [You may want to include]:**

**[Note: Exercise your medical judgment and discretion when providing a diagnosis**

**and characterization of the patient’s medical condition.]**

* **Patient’s diagnosis, condition, and history**
* **Previous therapies the patient has undergone for the symptoms associated  
  with their condition**
* **Patient’s response to these therapies**
* **Brief description of the patient’s recent symptoms and conditions**
* **Summary of your professional opinion of the patient’s likely prognosis or**

**disease progression without treatment with STELARA®**

**Rationale for Treatment**

Given the patient’s history, condition, and the published data supporting use of

STELARA®, I believe treatment of **[insert patient name]** with STELARA® is warranted,

appropriate and medically necessary. The attached copies of clinical peer-reviewed

literature and package insert document that STELARA® is an effective therapy for

patients like **[insert patient name]**.

Please call my office at **[insert telephone number]** if I can provide you with any

additional information. I look forward to receiving your timely response and approval of

this claim.

Sincerely,

**[Insert Doctor name and**

**participating provider number]**

Enclosures

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