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 include 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

Resources, support and education are available for your patients at www.AbbvieContigo.com or by calling 1-855-266-8446

Please see Indications and Important Safety Information on page 3.
Please see accompanying full Prescribing Information for additional information or visit https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

Skyrizi®
risankizumab-rzaa

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

Submission of a Letter of Medical Necessity does not guarantee coverage for the requested treatment.

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.

Digital version available at SkyriziHCPPR.com

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Indications and Important Safety Information

Indications[1]

Plaque Psoriasis: SKYRIZI is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Psoriatic Arthritis: SKYRIZI is indicated for the treatment of active psoriatic arthritis in adults.

Crohn's Disease: SKYRIZI is indicated for the treatment of moderately to severely active Crohn's disease in adults.

Ulcerative Colitis: SKYRIZI is indicated for the treatment of moderately to severely active ulcerative colitis in adults.

IMPORTANT SAFETY INFORMATION[1]

Hypersensitivity Reactions

SKYRIZI® (risankizumab-rzaa) is contraindicated in patients with a history of serious hypersensitivity reaction to risankizumab-rzaa or any of the excipients. Serious hypersensitivity reactions, including anaphylaxis, have been reported with the use of SKYRIZI. If a serious hypersensitivity reaction occurs, discontinue SKYRIZI and initiate appropriate therapy immediately.

Infection

SKYRIZI 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.

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.

Hepatotoxicity in Treatment of Inflammatory Bowel Disease

Drug-induced liver injury was reported in a patient with Crohn's disease who was hospitalized for a rash during induction dosing of SKYRIZI. For the treatment of Crohn's disease and ulcerative colitis, evaluate liver enzymes and bilirubin at baseline and during induction (12 weeks); monitor thereafter according to routine patient management. Consider an alternate treatment for patients with evidence of liver cirrhosis. Interrupt treatment if drug-induced liver injury is suspected, until this diagnosis is excluded. Instruct your patient to seek immediate medical attention if they experience symptoms suggestive of hepatic dysfunction.

Administration of Vaccines

Avoid use of live vaccines in patients treated with SKYRIZI. Medications that interact with the immune system may increase the risk of infection following administration of live vaccines. Prior to initiating SKYRIZI, complete all age-appropriate vaccinations according to current immunization guidelines.

Adverse Reactions

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

In psoriatic arthritis phase 3 trials, the incidence of hepatic events was higher with SKYRIZI compared to placebo.

Most common (>3%) adverse reactions associated with SKYRIZI in Crohn's disease are upper respiratory infections, headache, and arthralgia in induction, and arthralgia, abdominal pain, injection site reactions, anemia, pyrexia, back pain, arthropathy, and urinary tract infection in maintenance.

Most common (≥3%) adverse reactions associated with SKYRIZI in ulcerative colitis are arthralgia in induction, and arthralgia, pyrexia, injection site reactions, and rash in maintenance.

Lipid Elevations: Increases from baseline and increases relative to placebo were observed at Week 4 and remained stable to Week 12 in patients treated with SKYRIZI in Crohn's disease. Lipid elevations observed in patients with ulcerative colitis were similar to those in Crohn's disease.

Dosage Forms and Strengths: SKYRIZI (risankizumab-rzaa) is available in a 150 mg/mL prefilled syringe and pen, a 600 mg/10 mL single-dose vial for intravenous infusion, and a 180 mg/1.2 mL or 360 mg/2.4 mL single-dose prefilled cartridge with on-body injector.

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

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