**Sample Letter of Medical Exception and Medical Necessity for ANZUPGO® (delgocitinib)**

Use this sample letter when requesting a medical exception and demonstrating medical necessity for ANZUPGO. Modify as needed based on your clinical judgment and remember to address the health plan’s specific requirements. Use of the information in this letter does not guarantee that coverage for ANZUPGO will be granted, and it is not intended to be a substitute for, or an influence on, the independent medical judgment of the healthcare provider.

The coding information in this sample letter is provided for informational purposes only and is subject to change. The ICD-10-CM codes listed may not apply to all patients or to all health plans; it is the responsibility of the healthcare provider to select the appropriate ICD-10-CM code(s) and submit claims that accurately reflect the services and products furnished to a specific patient.

[Physician letterhead]

[Date]

Attn: [Insert health plan contact name] Patient name: [Insert patient name]

[Insert health plan name] DOB: [Insert patient’s date of birth]

[Insert health plan mailing address] Policy number: [Insert subscriber policy number]

Group number: [Insert subscriber group number]

Claim number: [Insert patient claim number]

**Re:** Request for Authorization of ANZUPGO® (delgocitinib) Cream

Dear [insert Medical Director name/name of health plan contact],

I am writing on behalf of the above-mentioned patient, [insert patient name], who was diagnosed with Chronic Hand Eczema (CHE) (ICD-10-CM code[s]: [Insert ICD-10-CM code(s). **Example codes include:** **Allergic contact dermatitis**: L23.0-L23.7, L23.81, L23.89, **Atopic dermatitis:** L20.89, L20.9, **Irritant contact dermatitis:** L24.0-L24.7, L24.81, L24.89, L24.A1, L24.A2, L24.A9, L24.B1-L24.B3, **Other and unspecified dermatitis:** L30.1, L30.8, L30.9]) on [insert date], to [document the medical necessity and support coverage for] [request a medical exception to cover] ANZUPGO. ANZUPGO was approved by the US Food and Drug Administration (FDA) on July 23, 2025 and is the first and only FDA-approved treatment for moderate-to-severe CHE.1

I have outlined below specific details that support my decision to prescribe ANZUPGO, including information about [insert patient’s name] condition severity and treatment history.

**Rationale for treatment**

When treating a patient with CHE, having access to the full spectrum of approved treatments is important, as patients may not be able to use a certain treatment because of lack of response or side effects, or because the use of topical corticosteroids is not advisable. Based on the information provided and enclosed, I have determined that treatment with ANZUPGO is medically appropriate and necessary and should be covered for [insert patient name].

**Severity of condition and patient’s symptoms**

[Include details on the chronicity (i.e., CHE >3 months or relapsed ≥2x within a year) and severity (i.e., if available, consider including results of an outcome measure used to document the severity) of your patient’s CHE.1,2 Consider mentioning other details related to the impact of CHE on your patient’s productivity and quality of life, as applicable.]

[You may also provide additional background regarding your patient’s condition to help reinforce the medical necessity of ANZUPGO (i.e., high-risk occupation, comorbidities, allergies, other relevant medical history, etc.), based on your clinical discretion.]

**Treatment history**

[Include previous treatments with start and stop dates, duration, and response to therapy. Note any current treatments, and/or provide reasons for discontinuation of previous treatments. Remember to list contraindications and inadequate responses or therapies that were not well tolerated.]

[Additionally, you may use this section to attest that ANZUPGO will not be used with other Janus kinase (JAK) inhibitors (including topicals) or potent immunosuppressants.1,2]

As you consider this request for coverage, please also refer to the enclosed materials. If you require additional information, please contact me at the phone number provided below. I look forward to receiving your timely response and coverage determination.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

[Insert physician’s name]

[Insert NPI #]

[Insert practice address]

[Insert practice phone number]

**Enclosures:** [ANZUPGO Prescribing Information, clinical trial publication(s), clinical notes/medical records, documentation of age-appropriate vaccinations as recommended by current immunization guidelines, including herpes zoster vaccinations,1 peer-reviewed literature, photos documenting improvement of patient’s condition (indicate dates each photo was taken, if possible), copy of the patient’s health plan or prescription card (front and back)]

**References: 1.** ANZUPGO Prescribing Information. LEO Pharma. **2.** Bissonette R, Warren RB, Pinter A, et al. Efficacy and safety of delgocitinib cream in adults with moderate to severe chronic hand eczema (DELTA 1 and DELTA 2): results from multicentre, randomised, controlled, double-blind, phase 3 trials. *Lancet*. 2024;404(10451)(suppl index):1-33. doi:10.1016/S0140-6736(24)01027-4