Sample Letter of Appeal

Instructions for Use:

Below is a template for your reference when drafting a Letter of Appeal. Please submit your letter on your office letterhead and replace all bracketed information with the patient-specific information.

As a reminder, the information contained in this sample letter is provided for informational purposes only. Providers are responsible for identifying and including any payer-specific requirements to ensure the accuracy and completeness of all information and materials submitted when requesting coverage for an individual patient. Please refer to the full Prescribing Information for FOTIVDA® (tivozanib), including Important Safety Information, when determining whether the therapy is clinically appropriate for your patient.

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Full Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number]
Case ID Number: [Case ID Number (if available)]

To Whom It May Concern,

I am writing on behalf of my patient, [patient name], to request reconsideration for the coverage of FOTIVDA® (tivozanib) treatment which was denied on [date] for the following reason: [describe reason given in denial letter]. For your convenience, I have attached documentation supporting my request for reversal of coverage denial:

- ◅ The prior authorization request for [patient name] which was denied on [date]
- ◅ The patient's relevant medical history, diagnosis, and treatment plan
- ◅ Clinical rationale supporting FOTIVDA treatment for [patient name]

Patient's Clinical/Medical History

- ◅ [Patient's ICD-10-CM diagnosis code and date of diagnosis]
- ◅ [Patient's first visit date and date of referral]
- ◅ [Severity of patient's condition]
- ◅ [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- ◅ [Patient's disease progression]
- ◅ [Any additional factors impacting FOTIVDA treatment selection]

Treatment Plan

- ◅ [Include plan of treatment: dosage, frequency, and length of treatment]
- ◅ [Clinical rationale for the use of FOTIVDA]

Summary

Given the provided evidence, I am confident you will agree treatment with FOTIVDA is medically necessary. It is crucial that [plan name] allow the use of FOTIVDA and provide coverage so [patient name] receives the care they need. We appreciate your prompt review and reconsideration of this case. If you need additional information, please contact my office at [insert office phone number].

Sincerely,

_____

[Physician Name]
[Physician Address]
[Physician Phone]

Enclosures: [Full prescribing information, patient medical history, clinical notes, relevant peer-reviewed articles, clinical practice guidelines, FDA approval letter, etc.]