Instructions:
This template is offered as a resource a healthcare provider could use when responding to a request from a patient's insurance company to provide a letter of appeal for prescribing DATROWAY. Attachments to be included with the letter of appeal are required insurer forms, Prescribing Information, copy of denial or explanation of benefits, and any other additional supporting documents.

When determining if treatment with DATROWAY is medically appropriate for a patient, please refer to the full Prescribing Information and Medication Guide.

Use of the letter does not guarantee that the insurance company will provide reimbursement for the medicine requested, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Appeal
(Healthcare Provider Letterhead)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of [Product Name]
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]

To whom it may concern:

I am writing on behalf of my patient, [Name of Patient], to appeal [Name of Health Insurance Company]'s decision to deny coverage for DATROWAY indicated for the treatment of (specific diagnosis). It is my understanding based on your letter of denial dated [Date] that coverage has been denied for the following reason(s): [List the Specific Reason(s) for the Denial as Stated in the Denial Letter].

Patient History and Diagnosis

[Provide a Brief Description of the Patient's Medical Condition Here]
[Include a Short Summary of the Patient's Medical History, including documentation of relevant biomarker testing results, previous treatment regimens, and duration of use]
[Explain why you believe it is Medically Necessary for Patient to receive DATROWAY]
[Describe the Potential Consequences to the Patient if they do not receive DATROWAY]
[Obtain and Attach Supporting Letters of Medical Necessity from any Specialist that is providing or has provided Care to the Patient]
[Include DATROWAY indication information.]
[Include DATROWAY administration information.]

Thank you in advance for your immediate attention to this written appeal.

Sincerely,

[Physician's Name]
[Physician's Practice Name]
References
[Include DATROWAY full FDA-approved Prescribing Information]

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