ON OFFICE LETTERHEAD INCLUDING PROVIDER NAME AND ADDRESS

SAMPLE LETTER OF APPEAL: COVERAGE DENIAL

<Date>
<Payer Name>
<Payer Address>

Attn: <Appeals Department>

Re: <Patient Name>
<Policy ID/Group Number>
<Date of Service>
<Disputed Amount>

To Whom It May Concern:

I am writing to request an appeal of the coverage denial for <Patient Name> for the administration of FIRAZYR® (icatibant injection). FIRAZYR was approved by the U.S. FDA in August 2011 for the treatment of acute attacks of Hereditary Angioedema (HAE) in adults 18 years of age and older.

The reasons provided by <Payer Name> for the denial of coverage were <list reason(s) for coverage denial>. I disagree with this decision and request that this coverage decision be reversed.

In my clinical judgment, treatment with FIRAZYR is medically necessary. <Provide clinical justification for treatment>.

I have enclosed additional documentation that supports treatment with FIRAZYR. If you have any further questions, please feel free to call me at <Physician Telephone #> to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

<Physician Name>

<Enclosures: formulary exception form (if required, available on the payer's website), original denial/EOB and subsequent denial/EOB (if relevant), patient medical history, full Prescribing Information, additional supporting documents>