Sample Letter of Appeal

[Physician Practice Letterhead at the top of the letter]
[Date]

[Name of Medical Director]
[Name of Insurance Company]
[Address]
[City, State Zip Code]

Re: [Patient's Name, Group Policy Number, Date of Birth] – Letter of Appeal for AYVAKIT™ (avapritinib)

Dear [Medical Director Name],

Please consider this letter an appeal of your decision to deny coverage [Insert Denial Reason, if known] for AYVAKIT for my patient, [Patient's Name]. I am requesting that you review my patient's denied claim for coverage and reverse your previous decision.

I have included additional information to support my decision to treat my patient with AYVAKIT. In my clinical judgement, AYVAKIT (as you will note from the information below and attached) is medically necessary and appropriate for [Patient's Name]. This letter includes information on [Patient's Name] medical history, prognoses and my medical rationale for selecting AYVAKIT to be used.

Summary of Medical History

[Patient's Name] is a [Age, Gender]. [He/She] was diagnosed with [Insert description of disease or condition] on [Date].
[Include a brief description of patient's medical history and attach patient's chart notes].
[Include AYVAKIT Package Insert and note that use is within labeled indication].

Treatment Rationale

Given my patient's medical history, [the lack of response to other medications] and the patient's current condition and prognosis, I strongly believe that the use of AYVAKIT for [Patient's Name] is medically necessary and appropriate and coverage should be approved.
[Include NCCN guidelines]

Please call me or my office staff at [Physician's telephone number OR Practice telephone number] if I can provide you with any additional information. I look forward to receiving your timely response and approval for treatment with AYVAKIT for [Patient's Name].

Sincerely,

[Prescriber's Signature]

[Prescriber's Name]

[Attachments: Enclose supporting documentation]