[Insert Date]

Request for Patient to Remain on [Insert Product Name]

[Optional: Claim rejection number]

RE: [Patient Name], [Patient Insurance ID Number], [Patient Date of Birth]

Dear [Health Plan Contact Name]:

This letter is regarding your coverage policy that requires me to take my patient off of [Insert Product Name].

I have been working with my patient since [Insert Date] to manage their disease. My patient has been on [Insert Product Name] since [Insert Date], and during this time my patient has shown the following results with treatment, as summarized below:

- [Insert information about lesion activity, or lack thereof as evidenced by MRI data; include dates of MRI scans]
- [Insert information about changes in disability status, or lack thereof; include dates of assessment]
- [Insert information about relapse status]

In my medical opinion, I believe that converting therapy is not the right choice based on my clinical judgment for the following reasons: [Insert reasons(s)].

I have included additional documentation regarding my patient, which supports my decision. I ask that you review the information I have indicated below when reviewing my request:

- ☐ Relevant medication history
- ☐ Anti-JCV antibody status
- ☐ MRI data
- ☐ Patient's history of relapses
- ☐ EDSS history

The previous disease-modifying therapies for this patient include

| **Medication** | **Strength** | **Dates of therapy** | **Reason for failure/discontinuation** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

[Provide reason that [Product Name] is the most appropriate treatment for this patient based on medical history, positive or negative anti-JCV antibody status, MRI data, history of relapses, EDSS history, or other factors.]

In the case that this appeal is denied, I am also at this time requesting a peer to peer with a plan Medical Director. Please feel free to contact me if you require further information regarding this request. I look forward to your response as soon as possible.

Sincerely,
[Name]