***Cover Letter for Sample Letter of Appeal***

**The following pages may be customized to use as a letter of appeal for treatment with**

**a disease-modifying therapy for a patient with multiple sclerosis.**

The following sample letter is intended to be used as a guide; therefore it is important to tailor the letter to the specific needs of your patients and address the reason(s) why the prescribed disease-modifying therapy is the appropriate treatment option. You should always include pertinent clinical information that supports your decision.

Please see below for considerations when writing a letter of appeal:

* Review the health plan’s denial and state the reason(s) you disagree with the denial. Also include any criteria that your patient meets per the health plan’s medical policy, and an explanation for why your patient should be excluded from any criteria that he/she/they do(es) not meet
* Provide background on your patient’s condition and clearly state your patient’s individual circumstances to justify why the prescribed therapy is the appropriate choice
* Provide clinical justification and include copies of relevant clinical data to support your decision (e.g., chart notes, MRI data, etc.)
* Submit the appeal as required by health plan and state guidelines. It is important that you understand the appeals process for each health plan, including how to submit the appeal (fax, phone, email, the company’s website, etc.), when the appeal must be filed per the health plan’s time limits, as well as how and when the decision will be communicated
* Track the status of your appeal and follow-up with the health plan as needed

[Insert Date]

[Insert Drug Name (generic)] Letter of Appeal

RE: [Patient Name]

[Patient Insurance ID Number]

[Patient Date of Birth]

[Reference Number]

Dear [Health Plan Contact Name]:

I am writing this letter on behalf of [Patient Name] to appeal a coverage denial for [Drug Name (generic)] that was issued on [MM/DD/YY]. [Drug Name] is a United States Food and Drug Administration (FDA)-approved therapy indicated for the treatment of patients with relapsing forms of multiple sclerosis (RMS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults. The full prescribing information for [Drug Name] can be accessed at [insert hyperlink to prescribed disease-modifying therapy’s PI].

The reason[s] for denial of [Drug Name] [is/are] stated as [reason(s) for denial]. I disagree with this decision because [reason(s) you disagree with the denial]. This letter and the attached documentation provide support for the use of [Drug Name] for this patient.

As a board-certified [field of certification] with [XX] years of experience treating MS, I believe that the RMS medication[s] preferred by your coverage policy [is/are] not appropriate for my patient’s MS. Utilizing [name of product(s)] before [Drug Name] is not appropriate for [him/her/them] because [list reason(s) medication(s) are not appropriate such as safety, efficacy, contraindications, tolerability, route of administration, etc.]. [HCP to state the number of years they have been treating the patient and their opinion on the necessity of treating with the prescribed therapy].

[The previous disease-modifying [therapy/therapies] for this patient include:]

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication** | **Strength** | **Dates of Therapy** | **Reason for Failure/Discontinuation or Contraindications** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

I have evaluated my patient’s clinical symptoms and have provided a summary below:

* [Date of diagnosis and ICD-10 code(s)]
* [Magnetic resonance imaging (MRI) data]
* [Physical disability, including description and related test results (eg, Expanded Disability Statis Scale (EDSS) score)]
* [History of relapse(s), including dates and symptoms]
* [Pertinent laboratory values]

[HCP to insert the reasons for recommendation to use the prescribed therapy, which may include:]

* [Reason(s) [Drug Name] is most appropriate for this patient, such as efficacy profile of this product, safety and tolerability profile of this product, pharmacokinetic profile, dosage, and/or route of administration]
* [Additional reason(s) why [Drug Name] is the most appropriate treatment for this patient based on medical history and comorbidities (heart disease, hypertension, liver disease, etc.), MRI data, history of relapses, or EDSS history]

I ask that you review any clinical information submitted regarding the patient when considering this request, as well as review clinical guidelines and recent clinical trial results. I have indicated the additional information which has been submitted with this letter below:

[[ ]  Relevant medication history and/or chart notes describing previous therapies and specific outcomes]

[[ ]  MRI data]

[[ ]  Patient’s history of relapses]

[[ ]  EDSS history]

[[ ]  Screening test results]

[[ ]  Supporting literature (e.g., clinical guidelines, recent clinical trials, etc.)]

In summary, please approve coverage of [Drug Name] for the patient, [Patient Name]. I would appreciate prompt review of this appeal, as starting [Drug Name] immediately is warranted, appropriate, and medically necessary.

In the case that this appeal is denied, I am also at this time requesting a peer-to-peer discussion with a plan medical director of the same or similar specialty as myself, who typically manages the same or similar conditions and/or treatments. Please contact me if you require further information regarding this request. I look forward to your response as soon as possible.

Sincerely,

[Prescriber Name]

[Prescriber Specialty]

[Prescriber Contact Info]