Instructions:
This template is offered in response to a request from a healthcare provider for a sample resource a healthcare provider could use when responding to a request from a patient's insurance company to provide a letter of medical necessity when prescribing AstraZeneca medicines. **Attachments to be included with the letter of medical necessity are original claim form, copy of denial or explanation of benefits, and any other additional supporting documents.** If you need additional references, please contact our information center at 1-800-236-9933.

Use of the letter does not guarantee that the insurance company will provide reimbursement for AstraZeneca medications, and is not intended to be a substitute for, or influence, 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]**

Patient Name: **[Patient Name]**
Patient Date of Birth: **[Patient Date of Birth]**
Policy Number: **[Policy Number]**
Group Number: **[Number]**

RE: Appeal for FASENRA™ (benralizumab) Subcutaneous Injection 30 mg

Dear **[Name of the Contact Person at the Insurance Company]**:

I am writing on behalf of my patient, **[name of patient]**, to appeal [**name of health insurance company]**'s decision to deny coverage for FASENRA which has been prescribed to treat **[indication for prescription]**. 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]**.

[name of patient] is a **[age]** year old **[gender]** who has been under treatment for **[diagnosis]**. Their treatment regimen has included **[list past and/or existing treatment protocols as appropriate]**. **[patient name]** started on FASENRA via a free drug program on **[patient start date]** and has been receiving continuing treatment. Prior to starting FASENRA, **[patient name]**'s blood eosinophil count was measured as **[EOS count]** cells/µL on **[date]** as recorded in the enclosed documentation. Since that date, **[patient name]** has experienced **[number of exacerbations]** exacerbations and **[describe patients change in lung function or breathing]**. Based on this evidence, I believe **[patient name]** would benefit from continued FASENRA treatment.

Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of FASENRA™ (benralizumab) Subcutaneous Injection. I would appreciate a prompt review of this information and authorization of FASENRA by an **[allergist/pulmonologist]**. I can be reached at **[provider phone number]** or by fax at **[provider fax number]** for additional information and discussion. Thank you for your consideration.

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]
[Explain why you believe it is Medically Necessary for Patient to receive this Medicine. Include the following:
• Diagnosis and date
• Documentation of past treatments, including high-dose inhaled corticosteroids and/or additional controller medications
• Any test results that are relevant to past treatments
• Extenuating circumstances that would preclude alternatives to FASENRA™ (benralizumab)
• Social and family information that is relevant]

[Describe the Potential Consequences to the Patient if they do not receive this Medicine]
[Obtain and Attach Supporting Letters of Medical Necessity from any Specialist that is or has provided Care to the Patient, including unscheduled office or hospital visits]
[Include Medicine Indication Information] [Include Medicine Administration Information]

In summary, I am requesting **[an appeal/redetermination/reconsideration]** of the denial of FASENRA for **[patient name]** who I believe lacks other treatment options. I am requesting that you reconsider coverage based on the information provided above. I am available at my office phone **[phone number]** to address any questions or concerns regarding this appeal. Thank you in advance for your immediate attention to this written appeal.

Sincerely,
[Physician's Name]
[Physician's Practice Name]

Enclosures:
[Include Indication and Important Safety Information]
[Include full Prescribing Information, including Patient Information]

References:
[Include other relevant references and publications regarding medicine]
[Copy of patient denial letter]
[Clinical progress notes]
[Patient's lab results]
[Documentation of Hospitalization/ Emergency room visits and/or unscheduled office visits]
[List of medications provided including, dosages, dates used, and if samples were given]