

## 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 for 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]

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™ (benralizumab) Subcutaneous Injection 30mg which is prescribed to treat [Approved 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.]

### 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 failure of past treatments, including high-dose inhaled corticosteroids and/or additional controller medications
- Any test results that indicate failure of past treatments
- Extenuating circumstances that would preclude alternatives to FASENRA™ (benralizumab)
- Social and family information that is relevant]

[Describe the Potential Consequences of 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]

### Summary

In summary, I am requesting [an appeal/redetermination/reconsideration] of the denial of FASENRA™ (benralizumab) for [patient name]. [He/She is/has been diagnosis] who lacks other treatment options and is currently experiencing [symptoms]. 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 medicine Prescribing Information]  
[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 sample medications provided including, dosages, dates used, and if samples were given]