Sample Letter of Appeal-Product Change

Template Instructions:

This template is offered as a resource which a healthcare provider could use when responding to a letter of appeal where there is a product change when prescribing AstraZeneca products. As you review the template below, please note that you will need to populate or provide the information in bracketed pink font ([xxx]). **Commonly recommended attachments to be included when submitting the completed appeal are [original claim form, copy of denial or explanation of benefits, and any other additional supporting documents].** If you need additional references, please contact the AstraZeneca Information Center at 1-800-236-9933.

Use of this template does not guarantee reimbursement for the prescribed AstraZeneca product, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

IMPORTANT NOTE: This template is intended to be completed by the patient's treating physician. Prior to submission, please delete these instructions and complete all sections below.

[(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: [Group Number]

RE: Appeal Request for SAPHNELO® (anifrolumab-fnia) injection, for [Subcutaneous Injection 120 mg/0.8mL OR Intravenous Infusion, 300 mg/2mL]

Dear [Name of the Contact Person at the Payer],

I am writing on behalf of my patient, [Patient Name], to appeal [Name of Health Insurance Company]'s decision to deny coverage for SAPHNELO® (anifrolumab-fnia), for [Subcutaneous Injection OR Intravenous Infusion] 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 Name] is [a/an] [age]-year-old [gender] who has been under treatment for [diagnosis] since [date]. The treatment regimen has included [list past and/or existing treatment and patient's response to treatment]. Despite these measures, [describe treatment outcome].

[Patient Name] had [describe symptoms and disease history] for which I started them on [alternate Brand (R) (generic) name]. Since starting [alternate Brand (R) (generic) name] their [list the effects of using current product to support need for change] and I believe they would benefit from the use of SAPHNELO [list preferred outcome].

Once approved for SAPHNELO, I will discontinue prescription of [alternate Brand (R) (generic) Name] and the patient will not be receiving more than [list drug and drug type].

Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of SAPHNELO, for [Subcutaneous Injection OR Intravenous Infusion] use. I would appreciate a prompt review of this information and authorization of SAPHNELO. If you have further questions or you require additional information, please contact me at [Physician Phone Number].

Thank you in advance for your immediate attention to this written appeal.

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

References
[Include SAPHNELO PI]
[Include other relevant references and publications regarding SAPHNELO]
[Clinical notes & lab results]
[List of medications provided including dosages, dates used, and if samples were given]