**Sample Letter of Appeal**

**Template Instructions:**

This template is offered as a resource that a healthcare provider could use to submit an appeal request to a patient's insurance company when coverage for BAXFENDY™ (baxdrostat) has been denied. As you review the template below, please note that you will need to populate or provide the information in bracketed blue font ([xxx]).

**Documents typically included with the letter of appeal are a copy of the denial or explanation of benefits, any supporting documents, and Prescribing Information.** If you have questions, please contact our Information Center at 1-800-236-9933.

**Use of the Letter of Appeal does not guarantee that the insurance company will approve your request for BAXFENDY™ 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:** [Month Date, Year]
**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 BAXFENDY™ (baxdrostat)**

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 BAXFENDY™ (baxdrostat), 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 BAXFENDY]
[Describe the Potential Consequences for the Patient if they do not receive BAXFENDY]
[Obtain and Attach Supporting Letters of Medical Necessity from any Specialist that is or has provided Care to the Patient]
[Include BAXFENDY Indication Information]

[Include BAXFENDY Administration Information]

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

Sincerely,

[Physician's Name]
[Physician's Practice Name]

References:
[Include BAXFENDY PI]
[Include other relevant references and publications regarding BAXFENDY]