

LETTER OF APPEAL

Dear Health Care Provider:

We have provided this **sample Letter of Appeal** to assist with appeal of a denial for ELZONRIS™ (tagraxofusp-erzs) Injection for Intravenous (IV) Use. Use of this document does not guarantee coverage for the medication for your patient.

To use this letter, please copy the text from the next page and paste it onto your office letterhead. Be sure to replace all bolded and bracketed text with the appropriate patient-specific information before forwarding your customized letter to your patient's insurance provider. If necessary, please modify the provided fields to more accurately reflect your practice.

Tips for completing the disease and medical history fields:

- Include specific diagnosis codes where appropriate
- List previous therapy, length of therapy, and outcomes (i.e., specify reasons for unsuccessful results)
- Clearly state the rationale for the recommended therapy and why it is appropriate for your patient

Tips for completing the enclosed materials field:

- List and enclose documents that support your rationale for the recommended therapy:
 - Summary of patient's medical records
 - Journal articles
 - Copies of medical correspondence
 - Specific information about the recommended drug or procedure (Prescribing Information, FDA approval letter, treatment guidelines compiled by professional physician organizations)
- Be sure to include all the listed documents with the letter when you send it to your patient's insurance provider

We hope you find this **sample Letter of Appeal** to be a valuable resource to your practice.

Sincerely,

APPEAL

[Date]

[Name of insurance company]

[Insurance street address]

[City, state, ZIP code]

RE: Appeal for [Patient Name]

Member ID: [Patient ID number]

Date of Birth: [Patient date of birth]

Group Number: [Patient group number]

Dear [insurance contact name]:

I am writing on behalf of my patient, [Patient Name], to request prior authorization for ELZONRIS™ (tagraxofusp-erzs) Injection for Intravenous (IV) Use for the treatment of blastic plasmacytoid dendritic cell neoplasm (BPDCN).

This letter outlines [Patient Name]'s medical history, prognosis, and treatment rationale.

Summary of Patient History

- [Patient's diagnosis, condition, and treatment history]
- [Previous therapies the patient has undergone for the symptoms associated with disease]
- [Patient's response to past therapies tried and failed]
- [Brief description of the patient's recent symptoms and conditions]

[Summarize your professional opinion of the patient's likely prognosis or disease progression without treatment with ELZONRIS].

Based on the above considerations, I am confident you will agree that ELZONRIS is medically necessary for my patient. If you have any further questions, please feel free to call me at [Phone #] to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Signature]

[Name]