Sample Letter of Appeal

Below is a template for your reference when drafting a Letter of Appeal. The information contained in this sample letter is provided for informational purposes only. Providers are responsible for the accuracy and completeness of all information and materials submitted requesting coverage for an individual patient. Please refer to the full Prescribing Information for FOTIVDA® (tivozanib), including Important Safety Information, when determining whether the therapy is clinically appropriate for your patient.

[Date]
[Payer Name]
[Payer Street Address]
[Payer City, State, and Zip Code]
Patient Name: [Patient Full Name]
Date of Birth: [Patient Birth Date]
Member ID: [Patient Member ID Number]
Policy or Group Number: [Patient Policy or Group Number]
Case ID Number: [Case ID Number (if available)]

To Whom It May Concern,

I am writing on behalf of my patient, [patient name], to request reconsideration for the coverage of FOTIVDA® (tivozanib) treatment which was denied on [date] for the following reason: [describe reason given in denial letter]. For your convenience, I have attached documentation supporting my request for reversal of coverage denial:

- ◅ The prior authorization request for [patient name] which was denied on [date]
- ◅ The patient's relevant medical history, diagnosis, and treatment plan
- ◅ Clinical rationale supporting FOTIVDA treatment for [patient name]

Patient's Clinical/Medical History

- ◅ [Patient's ICD-10-CM diagnosis code and date of diagnosis]
- ◅ [Patient's first visit date and date of referral]
- ◅ [Severity of patient's condition]
- ◅ [Previous treatments including drug names and duration, responses to those treatments, and reason for discontinuation]
- ◅ [Patient's disease progression]
- ◅ [Any additional factors impacting FOTIVDA treatment selection]

Treatment Plan

- ◅ [Include plan of treatment: dosage, frequency, and length of treatment]
- ◅ [Clinical rationale for the use of FOTIVDA]

Summary

Given the provided evidence, I am confident you will agree treatment with FOTIVDA is medically necessary. It is crucial that [plan name] allow the use of FOTIVDA and provide coverage so [patient name] receives the care they need. We appreciate your prompt review and reconsideration of this case. If you need additional information, please contact my office at [insert office phone number].

Sincerely,

_____

[Physician Name]
[Physician Address]
[Physician Phone]

Enclosures: [Full prescribing information, patient medical history, clinical notes, relevant peer-reviewed articles, clinical practice guidelines, FDA approval letter, etc.]