



Dear Health Care Provider:

We have provided this **Sample Letter of Appeal** (attached below) to support resolving a prior authorization denial for an Otsuka product. Use of this document does not guarantee coverage for the medication for your patient.

To use this letter, please fill in all bracketed text and print on your office letterhead. Be sure to replace all bracketed text with the appropriate patient-specific information before forwarding your customized letter to your patient's insurance provider. If the provided fields do not accurately reflect your practices, please modify them to represent your circumstances.

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 (i.e., copy of denial letter)
  - Specific information about the recommended drug or procedure (Package Insert, 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 the **Sample Letter of Appeal** to be a useful resource.

Sincerely,

Otsuka Patient Support

<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>

To whom it may concern:

This is a formal letter of appeal for reconsideration of coverage for <Patient Name> for <PRODUCT®(generic)> for the treatment of <Disease>.

<Patient Name> has been under treatment for <Disease> since <Date of Onset>. <Insurance Company> has stated that <PRODUCT® (generic)> is not covered because <Denial Reason>.

### **Patient History and Diagnosis**

<Patient Name> is a <Age>-year-old <male/female> who has been treated for <Disease> since <Date>. During this time, <he/she> has been treated with other therapies with unsuccessful results.

Specifically my patient has <tried and failed> the following therapies:

- <List therapy, length of therapy, and outcome (ie, specify reason(s) for unsuccessful results)>
- <List therapy, length of therapy, and outcome (ie, specify reason(s) for unsuccessful results)>

<PRODUCT® (generic)> is medically appropriate for my patient for the following reasons:

- <Insert treatment rationale as to why (drug name) is medically appropriate>
- <Insert treatment rationale as to why (drug name) is medically appropriate>

To support my appeal, I have included the following documentation enclosed for your review:

- <Patient's progress notes outlining diagnosis of disease>
- <Documentation of treatment history, past therapies prescribed, and outcomes>
- <Rationale as to why the patient is appropriate for <PRODUCT® (generic)>
- <Denial letter from prior authorization request>
- <PRODUCT® (generic)>Package Insert>

It is crucial that <Insurance Company> provide coverage for <PRODUCT® (generic)> for this patient as this treatment is medically appropriate. On behalf of <Patient Name>, we would appreciate your prompt reconsideration of coverage for <PRODUCT® (generic)>. Please call me at <Phone #> if I can be of further assistance or if you require additional information.

Sincerely,

<Treating Provider Name>