SAMPLE LETTER TO APPEAL DENIAL OF COVERAGE

Please Note: This letter is intended as an example for consideration and may not include all the information necessary to support an appeal of denial of coverage for your patient. The information required for an appeal may vary based on the health plan guidelines and patient benefit design. Please note the requesting provider is entirely responsible for ensuring the accuracy and completeness of all information submitted, as well as any and all medical judgments reflected in that information (e.g., medical necessity, etc.) Further, the requesting provider is solely responsible for submission to and follow-up with the health plan regarding any appeal. Use of this sample document does not guarantee coverage or reimbursement.

[PRESCRIBER LETTERHEAD]

(Date)
(Payer name)
ATTN: APPEALS
(Type in payer name)
(Type in payer address)

Patient: (Type in patient's first and last name)
Subscriber ID#: (Type in insurance ID#)
Subscriber Group #: (Type in insurance group#)
Re: NOURIANZ™ (Istradefylline) tablets, for oral use
Dates of Service: (Include all denied dates of service)

Dear Appeals Reviewer:

I am writing to request appeal of the above denial(s) of Nourianz™ (istradefylline) for my patient [patient name]. I understand from your denial letter that the denials were based on [denial reason]. I would like to address [that reason/those reasons] now.

On August 27, 2019, the FDA approved Nourianz, an adenosine receptor antagonist, for adjunctive treatment to levodopa/carbidopa in adult patients with Parkinson's disease (PD) experiencing "OFF" episodes."

Please see the enclosed documentation demonstrating the medical necessity of Nourianz as an adjunct treatment for my patient, [Patient's name]. (He/she) has Parkinson's disease, and is experiencing "OFF" episodes on levodopa/carbidopa. I would appreciate prompt review of this information for authorization of Nourianz.

Patient's Clinical History
[Patient's name] is a [age] year old [male/female] who was diagnosed in [date] with Parkinson's disease. [Patient's name] has been treated with levopdopa/carbidopa for [X] years. Patients with Parkinson's disease who are on levodopa/carbidopa and other concomitant anti-parkinson medications experiencing "OFF" episodes, have limited treatment options.

[He/She] underwent [describe treatment to date].
- [Be sure to include diagnosis and dates]
- [Past treatments]
- [Patient's ability to manage current disease]
- [Social & family information (especially if younger patient)]

[i.e. young children or grandchildren, contributes to the well-being of the family, part-time work, volunteer work]

Treatment Rationale
Nourianz™ (istradefylline) was approved by the FDA on Aug 27, 2019, as adjunctive treatment to levodopa/carbidopa for the treatment of adult patients with Parkinson's disease (PD) experiencing "off" episodes. This approval was based on results from 4, 12-week registrational trials that demonstrated that patients with istradefylline plus levodopa/carbidopa experienced a greater reduction in OFF time compared with patients treated with placebo plus levodopa/carbidopa.

Nourianz is the only adenosine receptor antagonist indicated to reduce OFF episodes thus providing an alternate MOA to potentially address this patient's medical need.

Summary
In summary, I am appealing the denial(s) of Nourianz as an adjunct therapy for my patient, [Patient Name]. [He/She] was diagnosed with Parkinson's disease and is experiencing "OFF" episodes on levodopa/carbidopa. As you know, there are limited treatment options for "OFF" episodes. I am requesting that you reconsider coverage based on the information above. I am readily available at my office phone [MD phone#] to address any questions or concerns you might have regarding this appeal.

Thank you for your time and consideration.

Sincerely,
(Physician's name and credentials)

Suggested Enclosures

USPI

Relevant clinical/chart notes