Appeal Letter Checklist

EveryDay Support. FROM DAY ONE

Considerations for Submitting an Appeal Letter

- It is important to understand the health insurance plan's appeal process, required forms, and deadline for submitting the appeal. EveryDay Support From Day One™ can help confirm the process, gather the required forms, and help confirm the reason for denial. Alternately, you can call the health insurance plan directly, if you prefer
- Review the prior authorization (PA) submission for errors. **If there was inaccurate information in the PA submission, call the health insurance plan to correct it**
- Carefully review the reason for denial, if provided
- Write an Appeal Letter documenting the medical necessity and rationale for treatment. Be sure to address the reason for denial and include any forms required by the health insurance plan

Information to Include in an Appeal Letter

- ☐ **Patient Information:** Patient's first and last name, date of birth, insurance group number, insurance policy number, and patient case ID number
- ☐ **Prescriber Information:** Prescriber's first and last name and credentials, prescriber's NPI number, office name and address, office telephone/fax numbers, and email address
- ☐ **Patient's Medical History**
  - Patient's age, diagnosis, date of diagnosis, BRAF alteration type, and relevant ICD-10-CM code(s)
  - Treatment history, including previous treatments and reason for discontinuation of prior therapies
  - Documented disease progression or lack of response
  - Current medical condition and description of disease severity (include any sequelae or tumor complications to reinforce the need for treatment)
- ☐ **Treatment Rationale and Supporting Documentation**
  - Pathology reports and/or molecular testing reports documenting BRAF alteration
  - Recent imaging report(s)
  - Tumor board recommendation (if available)
  - FDA approval letter, dosing and **prescribing information**, and clinical trial data/information
- ☐ **Request a Review of the Denial Decision**
  - Include the denial reason and date of denial, as provided by the health insurance plan
  - Explain why the health insurance plan's preferred treatment option may not be appropriate for this patient
  - Request the denial to be overturned based on medical necessity and your clinical judgment
- ☐ **Enclose the Original Letter of Medical Necessity**

See next page for sample Appeal Letter

If you have questions about submitting an Appeal Letter, please call EveryDay Support From Day One at 855-DAY1-BIO/855-329-1246.

Day One BIOPHARMACEUTICALS

Sample Appeal Letter

Instructions: Below is a sample appeal letter that can be used as a template. Please customize this letter by replacing the text in red with patient-specific details. It is recommended that this letter be written on practice letterhead.

[Date]
[Insurance company]
Attn: [Contact Name]
[Street address]
[City, State ZIP]

Patient Name: [_____]
Policy #: [_____]
Group #: [_____]
Date of Birth: [_____]
Case ID #: [_____]

RE: Appeal of Denial for [Patient's Name]

To Whom It May Concern:

I am writing on behalf of [Patient's Name] to appeal the denial of coverage for OJEMDA™ (tovorafenib).

On [Date], my request for coverage of OJEMDA for [Patient's Name] was denied due to [include denial reasons]. I am now requesting that you reconsider and reverse your decision.

I have included additional information to support my decision to treat my patient, including information on [Patient's Name] medical history and my medical rationale for selecting OJEMDA to be used.

Treatment Rationale
Based on my patient's medical history, it is my clinical judgment that OJEMDA is medically necessary and appropriate for [Patient's Name]. I believe not receiving this treatment would have the following impact:
[Impact of the patient not receiving treatment and explain why the health insurance plan's stated reason for denial and preferred treatment option may not be appropriate.]

Summary of Medical History
Below is a summary of [Patient's Name] medical history:

- [Patient's age, diagnosis, date of diagnosis, BRAF alteration type, and relevant ICD-10-CM code(s)
- Treatment history, including previous treatments and reasons for discontinuation, documented lack of response or tolerability, documented disease progression
- Current medical condition and description of disease severity (include any sequelae or tumor complications to reinforce the need for treatment)]

I have included the following clinical documentation in support of this matter:
[Attach relevant clinical documentation to support medication use.]

If you require additional information to support approval of treatment with OJEMDA, please contact me at [Physician's telephone/fax numbers and office email address]. I look forward to your response and approval for treatment with OJEMDA.

Thank you for your consideration.

Sincerely,

[Physician's Name and Credentials]

[Attachments: Enclose supporting documentation]