

Appeal checklist and sample appeal letter

If a health plan receives a prior authorization (PA) request and denies coverage for the prescribed medication for your patient, you may appeal the decision. You can use the enclosed checklist to help ensure you have taken appropriate steps to appeal, and you can use or adapt the enclosed sample appeal letter if coverage for the prescribed medication is denied. This sample letter is provided for your guidance only.

Some health plans require an appeal letter along with additional documentation, such as:

- Appeal form, if provided by the plan
- Chart notes
- Test results
- Supporting clinical studies
- Peer-reviewed literature
- Prescribing Information for prescribed medication

It is important to note that supplying the above information for the appeal does not guarantee the health plan will provide reimbursement for prescribed medication. The enclosed checklist and sample letter are not intended to substitute for or influence your independent medical judgment.

Overview

There are numerous reasons why health plans may deny a PA for prescribed medication. Although the reasons vary by plan, some of the most common include:

- Errors in ICD-10-CM coding on the PA request
- Insufficient documentation on the PA request
- Health plan claims lack of medical necessity for prescribed medication
- Prescribed medication is not covered by patient's health plan

If a PA for prescribed medication is denied, you can use the following checklist to ensure you have taken appropriate steps to appeal. Please keep in mind, just as reasons for denial vary, so do health plans' requirements for the appeal. It is important to check with the patient's health plan to ensure you have all the information you need to proceed with the appeal.

For any questions or concerns, or to report side effects with a Sanofi Genzyme product for patients enrolled in the CareASSIST Patient Support Program, please contact CareASSIST at 1-833-930-2273, Monday-Friday, 9 AM-8 PM Eastern Time.

Sanofi Genzyme is committed to protecting the confidentiality of individuals' personal healthcare information. This letter may contain personal healthcare information and should only be viewed by the individual to whom it is addressed. Please contact CareASSIST at 1-833-930-2273 if you believe you have received this letter in error.

Appeal checklist

- ✓ **Confirm** that prescribed medication is covered by the patient's health plan for the appropriate diagnosis
- ✓ **Double check** the accuracy of the information provided on the initial PA request
 - Patient information
 - Coding (it is recommended to use the most specific applicable codes as possible)
- ✓ **Understand** the reason for the denial—it is often included in the explanation-of-benefits letter
- ✓ **Review** the plan's appeal guidelines
 - Deadline to submit appeal
 - Timeline of review by health plan
 - Number of appeals permitted
 - Fax number or email address to be used to submit the appeal letter and any additional required information
 - Required additional supporting documentation, such as:
 - Appeal form, if provided by the plan
 - Chart notes
 - Test results
 - Supporting clinical studies
 - Prescribing Information for prescribed medication
- ✓ **Clarify** any aspect of the appeal process with the health plan's review department
- ✓ **Prepare** a written appeal. The appeal should be written by the physician (see sample letter on next page). In some cases, the patient can write the appeal
- ✓ **Gather** all required supporting documentation needed to help defend your rationale for coverage for prescribed medication
- ✓ **Send** the written appeal, along with the supporting documentation, to the health plan for review
- ✓ **Follow up** with the plan on the status of the appeal
- ✓ **Save copies** of all appeal-related documentation, including:
 - Documents submitted with appeal letter
 - Documents received from patient's health plan
 - Health plan representative's contact information

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Sample appeal letter

[Use physician's letterhead]

[Date]

[Health Plan Contact Name]

[Title]

[Health Plan Organization Name]

[Address]

[City, State, ZIP]

Re: [Patient Name], Insurance Policy ID Number: [Policy ID Number], Group Number: [Group Number]
Claim Number: [Claim Number]

Dear [Health Plan Contact Name],

I am writing on behalf of my patient, [Patient full name], to appeal your denial of coverage for [PRODUCT]. It is my understanding that [PRODUCT] was denied because [state the specific reason the PA was denied].

I would like to explain why [PRODUCT] should be covered for [patient name]. Along with this letter, I am providing information about the patient's medical history and diagnosis (ICD-10-CM code: [insert code]), a statement summarizing my treatment rationale, and other documents that support the medical necessity of [PRODUCT] in this clinical case.

[Patient name] was diagnosed with [disease] on [date]. I believe [PRODUCT] is needed for the treatment of this patient. The patient's medical history includes [insert information that summarizes the patient's treatment history, response to past therapies, recent symptoms and conditions, and opinion of the patient's prognosis with and without treatment with [PRODUCT].]

Given [patient name]'s clinical condition and the information included in the supporting documentation, I ask you to reconsider your previous decision and to approve coverage for [PRODUCT].

On behalf of [patient name], I appreciate your reconsideration. If you require additional information, please contact me at [phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician's name, degree(s), and signature]

Enclosures: [Attach any additional documentation, as appropriate]