Sample Format Letter of Appeal

[Date]

[Contact Name]
[Insurance Company]
[Insurance Address]
[Insurance City, State Zip]

Re: [Patient First Name] [Patient Last Name]
[Policy Number]
[Group Number]
[Diagnosis]

Dear [Name or Contact]:

This letter serves as a formal appeal for reconsideration of coverage for Rubraca™ (rucaparib) [include the dosage form (tablets)], which was originally denied to [Patient First Name] [Patient Last Name], on [Date of Denial]. [Patient First Name] [Patient Last Name], has been under treatment for [Diagnosis] since [Date of Onset]. [Insurance Company Name] has stated that Rubraca is not covered because [Denial Reason].

Treatment Information

RUBRACA is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated as monotherapy for the treatment of patients with deleterious BRCA mutation (germline and/or somatic) associated advanced ovarian cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for RUBRACA. This indication is approved under accelerated approval based on objective response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trials.

Patient History and Diagnosis

[Patient First Name] is a [Age]-year-old female who has been under treatment for [Diagnosis] since [Date]. During this time, she has been treated with other therapies including [discuss previous therapies and patient's response to therapy]. **[*Insert Pertinent Patient Medical History, including diagnostic test results, patient's quality of life, and information regarding the patient's disease state by assessment tools/scales if applicable.*]**

Based on the information provided above, I have determined that treatment with Rubraca is medically necessary for [Patient First Name] [Patient Last Name]. I respectfully request that [Insurance Company Name] reconsider providing coverage for Rubraca for this patient.

Please call me at [Primary Treating Site Phone Number] if you require additional information pertinent to this appeal.

Sincerely,

[Treating Provider First Name] [Treating Provider Last Name], [Treating Provider Title]