# 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 for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy.

**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]