Sample Format Letter of Appeal/Letter of Medical Necessity

[Date]

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

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

ATTN: Prior Authorizations / Appeals

Requested Medication: Rubraca® (rucaparib) tablets, for oral use [Full name would include the dosage form]

Diagnosis: [Diagnosis]

To whom it may concern:

I am submitting this letter in support of the request for Prior Authorization for [Patient Name], dated [Date], for RUBRACA, a poly (ADP-ribose) polymerase (PARP) inhibitor indicated:

Ovarian cancer

- 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. (1.1)
- for the treatment of adult patients with a deleterious *BRCA* mutation (germline and/or somatic)-associated epithelial ovarian, fallopian tube, or primary peritoneal cancer who have been treated with two or more chemotherapies. Select patients for therapy based on an FDA-approved companion diagnostic for RUBRACA. (1.1, 2.1)

Prostate cancer

- for the treatment of adult patients with a deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer (mCRPC) who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy. (1.2, 2.1)
  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. (1.2)

[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. Insert the dosage information per the MD's Prescription]

Based on the information provided above, I have determined that treatment with Rubraca is medically necessary for [Patient Name]. I respectfully request that you consider approving coverage for Rubraca for [Patient Name]. Thank you for your prompt attention to this matter. If you need further information, please contact me.

Prescriber's Name:

NPI#:

Fax#:

Phone#:

References: