**Sample Letter of Appeal for a Denied Prior Authorization**

*This sample letter is for informational purposes only and is not meant to be a substitute in any way for a physician's independent clinical decision-making. There is no requirement that any patient or eye care professional use any Astellas product in exchange for this information. A letter of appeal may be used to appeal a denial from the patient's health plan for coverage for IZERVAY™ (avacincaptad pegol intravitreal solution). This template provides information that may be requested when sending a letter of appeal to a patient's health plan on behalf of a patient being treated with IZERVAY for geographic atrophy (GA) secondary to age-related macular degeneration (AMD). Submitting a letter of appeal does not guarantee coverage. It is important to review the specific health plan requirements and each plan's submission process before you use this template. Please refer to the full Prescribing Information when determining whether therapy is medically appropriate for your patient.*

*Please replace the pink, bracketed content with appropriate details and place the template in your standard practice letterhead.*

[Date]
[Health plan name]
ATTN: [Department]
[Medical/Pharmacy director name (if available)]
[Health plan address]
[City, State, ZIP Code]

[Patient's name]
[Patient's plan-specific member ID]
[Patient's date of birth]
[Case number]
[Dates of service]

Re: Letter of Appeal for IZERVAY™ (avacincaptad pegol intravitreal solution)

Dear [Medical/Pharmacy director name],

I, [Eye care professional name], am writing to request that you reconsider your denial of coverage for IZERVAY on behalf of [Patient's name] for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD), associated with the diagnosis code(s) [ICD-10 code(s)].

Based on the denial letter, it is my understanding that coverage for IZERVAY was denied because [state reason from health plan's letter]. For your reference, the denial letter is included, along with medical notes in response to the denial.

After reviewing the denial letter, I continue to feel that IZERVAY is the appropriate therapy for [Patient's name]. The relevant clinical history and information is attached. To summarize:

*[Explain why you believe the administration of IZERVAY is appropriate for this patient. This can include but is not limited to the following information to support your treatment decision, and should be based on your own clinical judgment for your specific patient – Remove this section in gray when you place in your practice letterhead]*

- [Patient has been diagnosed with geographic atrophy secondary to age-related macular degeneration for [X] number of years and has shown visual decline of 20/[XX] to 20/[XX] vision over the last [X] years/months]
- [Your clinical opinion on the patient's potential for continued progression of geographic atrophy and its impact on further vision loss/decline with and without treatment with IZERVAY (eg, potential impact to the patient's daily activities)]
- [If your patient is already being treated with IZERVAY, clinical considerations associated with treatment switch/stop based on your clinical judgment, the patient's response to IZERVAY to date, and why you are recommending continuance of IZERVAY treatment for your patient]

- [Patient's response to past therapies (can include documentation of patient satisfying any step-therapy requirements if applicable)]

Please fax your coverage decision to [Eye care professional fax #] or mail it to [Eye care professional business office address]. Please also send a copy of the coverage determination decision to [Patient name].

If you have any further questions about this matter, please feel free to contact me at [Eye care professional phone number] or via email at [Eye care professional email].

[We have read and acknowledge your policy for the responsible management of drugs in the geographic atrophy categories, and we/We] urge you to reconsider your denial of coverage for IZERVAY.

Thank you for your time and consideration. I am looking forward to your timely response.

Sincerely,

[Eye care professional's signature] [Eye care professional name] [Eye care professional NPI] [Name of practice] [Phone number]

Enclosures:
[List and attach additional documents, which may include:
- Denial letter from payer
- Letter of Medical Necessity
- IZERVAY Prescribing Information
- IZERVAY FDA Approval Letter
- Your clinical notes/medical records
- Other relevant medical studies, peer-reviewed articles and publications regarding IZERVAY
- Upcoming studies, data read outs, and clinical support documentation
- Result summary of tests (eg, OCT/fundus photos/autofluorescence/fluorescein angiogram)
- Any other information requested by the payer]

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