Sample Letter of Appeal

This sample letter is for instructional purposes only, and this template letter is not meant to substitute for a physician's clinical decision-making. There is no requirement that any patient or eye care professional use any Astellas product in exchange for this information. This template provides information that may be required when sending a letter of appeal to a patient's health plan. 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). 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 Important Safety Information in 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] [Patient's name]

ATTN: [Department] [Patient's plan-specific member ID]

[Medical/Pharmacy director name (if available)] [Date of birth]

[Health plan address] [Case number]

[City, State, ZIP code] [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 codes [ICD-10 codes]. We have read and acknowledge your policy for the responsible management of drugs in the geographic atrophy categories. We urge you to reconsider your denial of coverage for IZERVAY.

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, we continue to feel that IZERVAY is the appropriate therapy for [Patient's name]. The relevant clinical history and information is provided below.

- [Include information requested by payer]

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].

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 a denial letter, Letter of Medical Necessity, Prescribing Information, clinical notes/medical records]