ON OFFICE LETTERHEAD INCLUDING PROVIDER NAME AND ADDRESS

SAMPLE LETTER OF APPEAL: COVERAGE DENIAL

<Date>
<Payer Name>
<Payer Address>

Attn: <Appeals Department>

Re: <Patient Name>
<Policy ID/Group Number>
<Date of Service>
<Disputed Amount>

To Whom It May Concern:

I am writing to request an appeal of the coverage denial for <Patient Name> for the administration of TAKHZYRO® (lanadelumab-flyo). TAKHZYRO was approved by the U.S. Food & Drug Administration (FDA) in August 2018 and is indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in patients 12 years and older. In February 2023, the U.S. FDA approved the expanded use of TAKHZYRO® for prophylaxis to prevent attacks of hereditary angioedema (HAE) in pediatric patients 2 to <12 years of age.

The reasons provided by <Payer Name> for the denial of coverage were <list reason(s) for coverage denial>. I disagree with this decision and request that this coverage decision be reversed.

The patient has been diagnosed with HAE and in my clinical judgment, treatment with TAKHZYRO is medically necessary. <Provide clinical justification for treatment>.

I have enclosed additional documentation that supports treatment with TAKHZYRO. If you have any further questions, please feel free to call me at <Physician Telephone #> to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

<Physician Name>

<Enclosures: formulary exception form (if required, available on the payer's website), original denial/EOB and subsequent denial/EOB (if relevant), patient medical history, full Prescribing Information, additional supporting documents>