

## **Sample Letter of Appeal**

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when appealing a denial of coverage from a patient's insurance company. Use of this template or the information in this template does not guarantee coverage. It is not intended to be a substitute for, or to influence the independent clinical decision of, the prescribing healthcare professional.

[Date]  
[Insurance Company Contact]  
[Insurance Company Name]  
[Insurance Company Address]  
[Insurance Company City, State ZIP]

Re:  
Patient: [Patient's First and Last Name]  
Subscriber ID #: [Insurance Subscriber ID]  
Subscriber Group #: [Insurance Group ID]  
Date of Birth: [Patient's Date of Birth]

Dear [Insurance Company Contact]:

Please accept this letter as [Patient's First and Last Name]'s appeal to [Insurance Company Name]'s decision to deny coverage for VYEPTI™ (eptinezumab-jjmr) for [Indication and ICD-10 code].

I have read and acknowledge your policy for the responsible management of drugs in this category.

It is my understanding, based on your letter of denial dated [date of denial letter], that coverage for treatment with VYEPTI was denied because [insert specific reason as stated in the denial letter].

[Patient's First and Last Name] requests that you reconsider your denial of coverage of VYEPTI.

As you know, [Patient's First and Last Name] was diagnosed with [diagnosis] on [insert date of diagnosis], and I believe that [he/she] requires this medication for the reasons stated in the attached letter of medical necessity and accompanying documentation.

I hope that after reviewing the attached information, you will agree that VYEPTI is medically necessary for this patient. Should you require additional information, please do not hesitate to contact my office by calling [Practice Phone Number]. I look forward to receiving your timely response and approval of VYEPTI for [Patient's First and Last Name].

**Please see Important Safety Information below.**

Sincerely,

[Physician's Signature]  
[Physician's Name]  
[Provider Identification Number]  
[Name of Practice]  
[Phone Number]

[Patient's Signature]  
[Patient's Name]

Enclosures: (attach as appropriate)

- Letter of Medical Necessity

- VYEPTI Prescribing Information
- Patient clinical/diagnostic notes and relevant lab reports

### **Indication**

VYEPTI™ is indicated for the preventive treatment of migraine in adults.

### **Important Safety Information**

#### **CONTRAINDICATIONS**

- VYEPTI is contraindicated in patients with serious hypersensitivity to eptinezumab-jjmr or to any of the excipients. Reactions have included angioedema.

#### **WARNINGS AND PRECAUTIONS**

- **Hypersensitivity reactions:** Hypersensitivity reactions, including angioedema, urticaria, facial flushing, and rash, have occurred with VYEPTI in clinical trials. Most hypersensitivity reactions occurred during infusion and were not serious, but often led to discontinuation or required treatment. Serious hypersensitivity reactions may occur. If a hypersensitivity reaction occurs, consider discontinuing VYEPTI, and institute appropriate therapy.

#### **ADVERSE REACTIONS**

- The most common adverse reactions ( $\geq 2\%$  and at least 2% or greater than placebo) in the clinical trials for the preventive treatment of migraine were nasopharyngitis and hypersensitivity.

**For more information, see the enclosed full Prescribing Information including Patient Information.**