**[Letter of Appeal Template]**

[Date] Re:

[Insurance Company Contact] Patient: [Patient’s First and Last Name]

[Insurance Company Name] Subscriber ID #: [Insurance Subscriber ID]

[Insurance Company Address] Subscriber Group #: [Insurance Group ID]

[Insurance Company City, State ZIP] Date of Birth: [Patient’s Date of Birth]

Dear [Insurance Company Contact]:

It has come to my attention that [Patient’s First and Last Name] has been denied the use of VYEPTI® (eptinezumab-jjmr), an intravenous calcitonin gene-related peptide antagonist indicated for the preventive treatment of migraine in adults. It is my understanding, based on your letter of denial dated [date of denial letter (prior authorization denial letter #)], that coverage for treatment with VYEPTI [100 mg/300 mg] was denied because [insert specific reason as stated in the denial letter].

Please accept this letter as [Patient’s First and Last Name]’s appeal to [Insurance Company Name]’s decision to deny coverage for VYEPTI [100 mg/300 mg].

As you know, [Patient’s First and Last Name] was diagnosed with [diagnosis; ICD-10 code] as evidenced by [examples include: # of migraine days per month and/or Migraine Disability Assessment (MIDAS) and/or Migraine Physical Function Impact Diary (MPFID) and/or Headache Impact Test (HIT-6) scores] on [insert date of diagnosis].

[Continuation of therapy or dose escalation only]

[Patient’s First and Last Name] has utilized [number of doses] doses of VYEPTI [100 mg/300 mg]. Since the initiation of VYEPTI, the patient [examples include: has seen a reduction in migraine days and/or Migraine Disability Assessment (MIDAS) and/or Migraine Physical Function Impact Diary (MPFID) and/or Headache Impact Test (HIT-6) scores]. I’ve also included the history of prior treatments [and treatments attempted,] [(see attachment for chart notes)].

Treatment History

* [Prior Treatment Name], [treatment start and end date], and [reason for discontinuation (e.g., intolerance/lack of efficacy)]
* List all prior treatments in above format.
* List any treatments patient was unable to try due to inability to self-inject, contraindications, etc.

However, based on my patient’s treatment history and in accordance with the FDA labeling, it is my medical opinion that this patient would benefit from [initiation/continuation/reapproval] of the [100 mg/300 mg] dose to [further reduce/maintain reduction in] monthly migraine days (MMDs) and migraine severity. It is my clinical assessment that a [further/maintained] reduction in migraine days and migraine severity may have a positive [effect on other abortive medication use, effect on patient functioning, etc.].

Additionally, [Patient] could be at risk of migraine treatment disruption if unable to [initiate/continue/increase] the dosage of VYEPTI [at/to] [100 mg/300 mg]. [If applicable, insert potential risks of disruption to therapy: e.g., increased migraine days, additional provider visits, other migraine-related medical care etc.]. If coverage is still in question, I’d like to request a review of this documentation by a neurologist specializing in the treatment of migraine.

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].

## Sincerely,

[Physician’s Signature] [Physician’s Name]

[Provider Identification Number] [Name of Practice]

[Phone Number]

**Enclosures:** (attach as appropriate)

* Any original Letter of Medical Necessity
* Patient clinical/diagnostic notes and relevant lab reports
* Published clinical references supporting your letter