Sample Appeal Letter

<Date>
<Prior authorization department>
<Name of health plan>
<Mailing address>

Re: <Patient's name>
<Plan identification number>
<Date>

To whom it may concern:

We have reviewed and recognize your guidelines for the responsible management of medications within this class. We are requesting that you reassess your recent denial of Olumiant® (baricitinib) coverage. We understand that the reason for your denial is <copy reason verbatim from the plan's denial letter> However, we believe that Olumiant <insert dose> is the appropriate treatment for the patient. In support of our recommendation for Olumiant treatment, we have provided an overview of the patient's relevant clinical history below.

Patient's diagnosis*:

Patient's history, diagnosis, condition, and symptoms:

<Provide the information that is applicable to the primary diagnosis>

Please provide the following:

Primary ICD-10 diagnosis code <ICD-10 code> Other ICD-10 diagnosis code (if applicable) <ICD-10 code>

☐ A <specialist type> has either been consulted or is the prescribing physician for Olumiant

Please detail all past treatments:

Treatment	Dose	Start/stop dates	Reason(s) for discontinuation

Additional patient comorbidities or considerations:

<Please provide reason(s) that your patient would benefit from using this agent.>

<Please provide the clinical rationale for why your patient would benefit from using this agent prior to the payer-preferred agent.>

Supporting references for the recommendation:

<Provide clinical rationale for treatment; this information may be found in the Olumiant Prescribing Information and/or clinical peer-reviewed literature.>

Physician contact information:

Please feel free to contact me, <HCP name>, at <office phone number> or <patient's name> at <phone number> for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

<Physician's name and signature>
<Physician's medical specialty>
<Physician's NPI>
<Physician's practice name>
<Phone #>
<Fax #>

Patient's name and signature if required by payer
Encl: Medical records, supporting documentation, Letter of Medical Necessity, original denial letter