Appeal Letter Template Instructions


# An appeals letter may be helpful to appeal a denial of coverage. The following page is a template letter that healthcare providers can cut and paste onto their office letterhead.

**The appeals letter includes the type of information that payers may require to appeal a denial of coverage, such as:**

* The patient’s diagnosis, condition, and medical history
* Information about the treatment that was denied
* Information about your patient’s medical history and prior treatments
* A summary of your clinical assessment and rationale for requesting coverage
* Other documentation that supports your position

# Please note that this template is intended only as an example. Teva recommends confirming the information that is required to include in an appeal of a coverage denial with individual payers

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*Physician Letterhead*

[Insurance Company] Patient: [Patient’s first and last name]

[Address Line 1] Patient DOB: [Patient’s date of birth]

[Address Line 2] Policy ID: [Insurance ID #]

Policy Group: [Insurance Group #]

[Date]

Re: COPAXONE® (glatiramer acetate injection) coverage

Dear: [Payer Contact Name, Medical/Pharmacy Director], [Department]

I am writing this letter to appeal the denial of coverage for brand COPAXONE® [20 mg/mL or 40 mg/mL] on behalf of my patient, [patient’s name], born [date of birth], who has a diagnosis of [Multiple Sclerosis, G35]. Your organization cited [insert the reason for denial] as the reason for its denial. Please review the information below that supports use of this medication as approved by the U.S. Food and Drug Administration.

Based on a clinical assessment of my patient, the patient’s diagnosis, and medical history, brand COPAXONE® was prescribed. Below is a brief summary of [patient’s name] medical history and rationale for treatment with brand COPAXONE®.

**Patient’s Medical History and Treatment Rationale:**

* Patient’s medical history, diagnosis, and current condition (eg, signs, symptoms, functioning): [Provide a brief statement about the patient’s diagnosis and medical history, including any underlying health issues that affect your treatment selection]
* Prior treatments and response to those treatments: [If applicable, provide a list of current and past medications, as well as reasons for not prescribing a medication (eg, contraindications, drug interactions, lack of efficacy) and a summary of the patient’s experience with each medication, including clinical outcome, adverse drug reactions, and length of therapy]
* [Include a summary of why, based on your clinical judgment, your patient requires treatment with brand COPAXONE®]

**Summary of Rationale for Treatment:**

In summary, based on my clinical opinion, brand COPAXONE® is medically necessary and reasonable for [patient’s name]’s medical condition. I trust that the information provided, along with my medical recommendations, will establish the medical necessity of coverage for brand COPAXONE®.

Please contact my office at [office phone number] if I can provide you with any additional information to approve this request.

Sincerely, [Physician’s name]

Include enclosures as appropriate, such as excerpts from the patient’s medical record, relevant treatment guidelines, COPAXONE® Prescribing Information, and relevant clinical data.