

Sample Letter of Appeal
Patient New to OCREVUS or OCREVUS ZUNOVO

[Date]

[Physician Name]
[Health Care Practice Name]
[Health Care Practice Address]
[City, State ZIP]

[Insured Name and DOB]
[Patient Name]
[Patient Insurance ID#]
[Denial Reference Number]

Dear Medical or Pharmacy Director:

This letter of [insert level of appeal] appeal is in regards to your coverage decision for [OCREVUS® (ocrelizumab)|OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)]. Your policy is requiring my patient to use a treatment which will interfere with my ability to appropriately treat my patient with [relapsing forms of multiple sclerosis (RMS)|primary progressive MS (PPMS)]. I request that the [insurance name] denial decision be reversed and coverage approved for [OCREVUS|OCREVUS ZUNOVO], as it is medically necessary to treat the diagnosis of [RMS|PPMS]] ([ICD-10-CM code]).

[Patient name] symptoms and MS disease summary are:

- [MRI scan documentation and findings]
- [MS severity overview including disability status if relevant]
- [Past drugs and treatments that were tried and failed]
- [Allergic or skin reactions to certain medications]
- [Activities of daily living affected by current disease state]

The medical rationale for prescribing [OCREVUS|OCREVUS ZUNOVO] are:

- [Drug treatment recommendation for the patient]
- [Overview of the drug and its effectiveness for treating RMS or PPMS based on clinical trial results]
- [Supporting clinical trial data]
- [FDA approval data]

I have included relevant medical documentation, supporting clinical trial data and a copy of FDA approval supporting my request for the overturning of denial for [OCREVUS|OCREVUS ZUNOVO]. Please feel free to contact me if I can provide further information or a peer-to-peer review for your approval to overturn your denial and authorize [OCREVUS|OCREVUS ZUNOVO].

Sincerely,

[Physician name]
[Phone number]
[Fax number]