

Sample Letter of Appeal
Patient Switching From OCREVUS [IV] to 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] is in regards to your coverage decision for 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 multiple sclerosis. I request that [insurance name] denial decision be reversed and coverage approved for OCREVUS ZUNOVO as it is medically necessary to treat the diagnosis of [relapsing forms of multiple sclerosis (RMS)]primary progressive MS (PPMS)] ([ICD-10-CM code]). The appropriate treatment at this time is to change from OCREVUS® (ocrelizumab) [IV] to OCREVUS ZUNOVO.

[Patient name] has been treated since [Date] to manage their disease. [He|She|They] [has|have] been on OCREVUS [IV] since [Date].

The rationale for prescribing OCREVUS ZUNOVO includes:

- [Reason(s) supporting switching to new drug prescription]

Included with this letter of appeal for approval to change to OCREVUS ZUNOVO are relevant supporting medical documentation, including a letter of medical necessity, clinical trial information and FDA approval information. [Summarize reasons for the patient to convert to OCREVUS ZUNOVO]. Please contact me if I can provide further information or coordinate a peer-to-peer review to overturn your denial decision and authorize OCREVUS ZUNOVO.

Sincerely,

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