

Sample Letter of Appeal
Patient to remain on 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 that does not provide coverage for [OCREVUS® (ocrelizumab)|OCREVUS ZUNOVO™ (ocrelizumab and hyaluronidase-ocsq)] for the treatment of [relapsing forms of multiple sclerosis (RMS)|primary progressive MS (PPMS)] ([ICD-10-CM code]). Your policy is requiring my patient to use a treatment which will interfere with my ability to appropriately treat my patient with [RMS|PPMS]. I request that the [insurance name] denial decision be reversed and continued coverage be approved for [OCREVUS|OCREVUS ZUNOVO], as it is medically necessary to treat the diagnosis of [RMS|PPMS].

[Patient name] has been treated since [Date] with [OCREVUS|OCREVUS ZUNOVO]. [The patient has had the following experience on the drug:]

Included with this letter of medical necessity for the denial to be overturned and for [Patient name] to be approved to continue with treatment of [OCREVUS|OCREVUS ZUNOVO] are relevant medical history notes, supporting clinical trials information, letter of medical necessity and FDA approval data.

[Summarize the reason for the patient to remain on OCREVUS or OCREVUS ZUNOVO and list potential adverse health outcomes that could arise from the patient discontinuing drug utilization]. 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]