Instructions

This sample letter is for informational purposes only. Use of the sample letter provided below does not guarantee that the health plan will cover or reimburse TG Therapeutics medicines. It is not intended to substitute or influence the independent medical judgment of a healthcare provider. There is no requirement that any patient or healthcare provider use any TG Therapeutics product in exchange for this information.

Along with the letter, the following attachments may be required when filing an appeal:

- PA or claim denial
- Explanation of benefits
- Payer coverage policy
- Peer-reviewed publication(s)
- Any other additional supporting documents

Checklist

Patient Information:

- ☐ Full name
- ☐ Date of birth
- ☐ Insurance ID
- ☐ Insurance group number
- ☐ Case ID number (if applicable)

Clinical Rationale:

- ☐ Patient's diagnosis and the indication for the medicine being prescribed
- ☐ Severity of the patient's condition, including relevant test results and data to demonstrate current condition
- ☐ Summary of the patient's previous treatment(s) including: drug name(s), duration of treatment(s), treatment response(s), reason(s) for discontinuation, and recent symptom(s)/condition
- ☐ If a previous treatment resulted in additional care (e.g., hospitalization, side-effect management) and is a reason for discontinuation, include the details of the reasoning
- ☐ The clinical rationale for treatment, including trial data supporting the FDA approval, administration, and dosing information

Additional Enclosures:

- ☐ Prescribing information for the prescribed medication
- ☐ Relevant clinical documentation (e.g., history, medical physical, progress notes, and treatment history)
- ☐ Applicable coverage policies
- ☐ Medical literature, specialist recommendations, and guidelines regarding diagnosis and treatment selection

Sample Letter of Appeal

[Date]
[Payer Name]
[Payer Address]
[City, State, ZIP Code]
[Payer Phone and Fax Number]
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Member Identification Number: [Member Identification Number]
Group Number: [Number]
Claim Number: [Number]

Dear [Appeals Department, Insurance Company, or Contact]:

I am writing on behalf of my patient, [Patient Name], to appeal [Name of Insurance Company]'s decision to deny coverage for [Drug Name], which I prescribed for the treatment of [Diagnosis and ICD-10-CM code]. It is my understanding, based on your letter of denial dated [Date], that coverage has been denied for the following reason(s): [List the specific reason(s) for the denial as stated in the denial letter].

I disagree with this decision because [reason(s) you disagree with the denial (e.g., prior authorization received yet claim denied)]. This letter and the attached documentation provide support for the use of [Drug Name] for this patient.

I believe that the medication(s) covered by your health plan [is/are] not appropriate for treating my patient because [list reason(s) medication(s) are not appropriate (e.g., safety, efficacy, tolerability, route of administration)]. I believe treatment with [Drug Name] is medically appropriate and necessary because [insert rationale].

[Provide a brief description of the patient's:
- Medical history and MS diagnosis;
- Disease progression (e.g., history of relapse(s) including dates and symptoms, magnetic resonance imaging scans, pertinent laboratory values);
- Treatment history; and/or
- Current medical condition (e.g., severity and disability status).]

[Explain why treatment is the most clinically appropriate option for this patient, including:
- Efficacy, safety, and/or tolerability; and/or
- Dosage and/or route of administration.]

Considering [Patient Name]'s medical history, I believe that a treatment plan with [Drug Name] at this time is medically appropriate and necessary and should be a covered and reimbursed service. [This is substantiated by the enclosed:
- Prescribing information
- Medical guidelines (e.g., American Academy of Neurology, Consortium of Multiple Sclerosis Centers)
- Documentation from (insert specialist's name)]

Based on the information provided above and enclosed, I hope you agree that the use of [Drug Name] is medically necessary for [Patient Name]. Please contact me if any additional information is required

Thank you in advance for your immediate attention to this written appeal.

Sincerely,

[Physician's Name]
[Physician NPI Number]
[Physician's Practice Name]
[Physician's Practice Address]
[City, State, ZIP Code]
[Physician Phone and Fax Number]

Enc.