Instructions:
This template is offered as a resource a healthcare provider could use when responding to a request from a patient's insurance company to provide a letter of appeal for prescribing CALQUENCE® (acalabrutinib). Some or all of the following attachments may be helpful to include with the letter of appeal: required insurer forms, Prescribing Information, copy of denial or explanation of benefits, and any other additional supporting documents. If you need additional references, please contact AstraZeneca Access 360™ at 1-844-ASK-A360 (1-844-275-2360).

When determining if treatment with CALQUENCE is medically appropriate for a patient, please refer to the full Prescribing Information, including Patient Information.

Use of the letter does not guarantee that the insurance company will provide reimbursement for the medicine requested, and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Appeal
(Healthcare Provider Letterhead)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of CALQUENCE® (acalabrutinib)
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]

To Whom It May Concern:

I am writing on behalf of my patient, [Name of Patient], to appeal [Name of Health Insurance Company]'s decision to deny coverage for CALQUENCE® (acalabrutinib) for the treatment of [Diagnosis].

Patient History and Diagnosis

[Provide a Brief Description of the Patient's Medical Condition Here.]
[Re-emphasize why other options are not appropriate for the patient and specifically address any other drug options that the insurance company has suggested to use in place of CALQUENCE.]
[Include a Short Summary of the Patient's Medical History, including documentation of condition being treated and any previous therapies, including duration of use.]
[Explain why you believe it is Medically Necessary for Patient to receive CALQUENCE.]
[Describe the Potential Consequences to the Patient if they do not receive CALQUENCE.]
[Obtain and Attach Supporting Letters of Medical Necessity from any Specialist that is providing or has provided Care to the Patient.]

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

Sincerely,
[Physician's Name]
[Physician's Practice Name]

If this request is denied, I am requesting an expedited Exception review by a "Like" specialist.

Enclosures
[Include Indications and Important Safety Information]
[Include full Prescribing Information, including Patient Information for CALQUENCE]

References

[Include CALQUENCE PI]
[Include other relevant references and publications regarding CALQUENCE]

AstraZeneca Access 360™ provides patients and their providers access and reimbursement support for CALQUENCE. Reimbursement is not guaranteed.