Instructions:

This template is offered as a resource which a healthcare provider could use when responding to a letter of appeal- product change when prescribing AstraZeneca products. **Commonly recommended attachments to be included when submitting the completed letter of medical necessity are [original claim form, copy of denial or explanation of benefits, and any other additional supporting documents]**. If you need additional references, please contact the AstraZeneca Information Center at 1-800-236-9933.

Use of this template does not guarantee reimbursement for the prescribed AstraZeneca product, 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- Product Change

(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]

Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Number]

RE: Appeal for FASENRA® (benralizumab) Subcutaneous Injection 30 mg

Dear [Name of the Contact Person at the Payer]:

I am writing on behalf of my patient, [Name of Patient], to appeal [Payer]'s decision to deny coverage for FASENRA which has been prescribed to treat [indication for prescription]. 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].

[Name of Patient] is a [age] year old [gender] who has been under treatment for [diagnosis]. Their treatment regimen has included [List past and/or existing treatment protocols as appropriate]. Despite these measures, [describe treatment outcome].

[Name of Patient] had an Average Eosinophil Count (AEC) of [count] cells/μL as measured on [date] for which I started them on [alternate BRAND (R) (generic) Name]. Since starting [alternate BRAND (R) (generic) Name] their AEC has decreased to less than [count] cells/μL, but their [list the effects of using current product to support need for change] and I believe they would benefit from the use of FASENRA [list preferred outcome].

Once approved for FASENRA, I will discontinue prescription of [alternate BRAND (R) (generic) Name] and the patient will not be receiving more than [list drug and drug type].

Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of FASENRA. I would appreciate a prompt review of this information and authorization of FASENRA by an [allergist/pulmonologist]. I can be reached at [Provider Phone number] or by fax at [Provider Fax number] for additional information and discussion. Thank you for your consideration.

Sincerely,

[Physician's Name]
[Physician's Practice Name]

Enclosures
[Include Indication and Important Safety Information]
[Include full Prescribing Information, including Patient Information]

References
[Include other relevant references and publications regarding prescribed medicine]
[Copy of patient denial letter]
[Clinical progress notes]
[Patient's lab results]
[Documentation of Hospitalization/ Emergency Room visits and/or unscheduled office visits]
[List of medications provided including, dosages, dates used, and if samples were given]