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**Sample Letter of Appeal**

**Template Instructions:**

This template is offered as a resource a healthcare provider could use to submit an appeal request when coverage for SAPHNELO™ (anifrolumab-fnia) injection, for intravenous use has been denied by a patient’s health benefits company. As you review the template below, please note that you will need to populate or provide the information in bracketed pink font ([xxx]).

**Documents typically included with the letter of appeal are a copy of the denial or explanation of benefits, any supporting documents, and Prescribing Information.** If you have questions, please contact our Information Center at 1-800-236-9933.

**Use of this Letter of Appeal does not guarantee that the insurance company will approve your request for SAPHNELO and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.**

**IMPORTANT NOTE: This template is intended to be completed by the patient’s treating physician. Prior to submission, please delete these instructions and complete all sections below.**

[(*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:** [Group Number]

**RE: Appeal Request for SAPHNELO™ (anifrolumab-fnia) injection, for intravenous use, 300 mg/2 mL**

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

I am writing on behalf of my patient, [Patient Name], to appeal [Name of Health Insurance Company]’s decision to deny coverage for SAPHNELO™ (anifrolumab-fnia) injection, for intravenous use which is prescribed to treat [Approved 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].

[Patient Name] is a [age]-year-old [gender] who has been under treatment for [diagnosis] since [date]. The treatment regimen has included [list past and/or existing treatment and patient’s response to treatment].

[Provide a Brief Description of the patient’s Medical History]

[Explain why you believe it is Medically Necessary for patient to receive SAPHNELO]

[Describe the Potential Consequences on the patient if they do not receive SAPHNELO]

Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of SAPHNELO injection, for intravenous use. I continue to believe SAPHNELO is indicated and medically necessary for this patient and would appreciate your reconsideration. If you have further questions or you require additional information, please contact me at [Physician Phone Number].

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

Sincerely,

[Physician’s Name]

[Physician’s Practice Name]

References

[Include SAPHNELO PI]

[Include other relevant references and publications regarding SAPHNELO]

[Clinical notes & lab results]

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