**Sample Letter of Appeal-Product Change**

**Template Instructions:**

This template is offered as a resource which a healthcare provider could use when responding to a letter   
of appeal where there is a product change when prescribing AstraZeneca products. As you review the   
template below, please note that you will need to populate or provide the information in bracketed pink   
font ([xxx]). **Commonly recommended attachments to be included when submitting the completed   
appeal 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.**

**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]. Despite these measures, [describe treatment outcome].

[Patient Name] had [describe symptoms disease history] for which I started them on [alternate Brand (R) (generic) name]. Since starting [alternate Brand (R) (generic) name] their [list the effects of using   
current product to support need for change] and I believe they would benefit from the use of SAPHNELO [list preferred outcome].

Once approved for SAPHNELO, 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 SAPHNELO injection, for intravenous use. I would appreciate a prompt review of this information and authorization of SAPHNELO. 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]

[List of medications provided including, dosages, dates used, and if samples were given]