**Instructions:**

This template is offered as a resource that a healthcare provider could use when responding to a request for a letter of appeal–FOR CONCOMITANT USE WITH ANOTHER ATTR THERAPY 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. It is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.**

**Sample Letter of Appeal**–**FOR CONCOMITANT USE WITH ANOTHER ATTR THERAPY**

*(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 WAINUA[™] (eplontersen)

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

I am writing on behalf of my patient, [Name of Patient], to appeal [Name of Payer]’s decision to deny coverage for WAINUA which has been prescribed to treat polyneuropathy of hereditary transthyretin-mediated amyloidosis*.* 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].

[Patient’s Name] has been diagnosed with polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR-PN) mixed phenotype and requires WAINUA which is indicated to treat the polyneuropathy (PN) manifestation of hATTR. Many patients with hATTR have a mixed phenotype with features of both polyneuropathy (PN) and cardiomyopathy (CM). WAINUA is not indicated for the treatment of cardiomyopathy symptoms. The current stabilizer [product name], which was prescribed to treat CM, is not indicated to treat the patient’s polyneuropathy. I believe [Patient Name] would benefit from WAINUA to treat hATTR-PN.

Please see the accompanying enclosures and documentation from my office demonstrating the medical necessity of WAINUA. I would appreciate a prompt review of this information and authorization of WAINUA by a [neurologist/cardiologist]. 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]

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