Re: Coverage of ZYNLONTA™ (loncastuximab tesirine-lpyl)

[Date]

[Health Plan Name]

[Health Plan Representative]

[Health Plan Address]

[City, State ZIP Code]

[Fax Number]

Attn: [Health Plan Representative]

Attn: [Prior Authorizations/Appeals Department]

Subscriber: [Subscriber’s First and Last Name]

Patient: [Patient full name]

Policy #/Patient ID: [Policy #/Patient’s ID]

Group #: [Group #]

Patient Date of Birth: [Patient date of birth]

Diagnosis: [Diagnosis and Code]

Treatment Date/Claim #: [Treatment Date/Claim #]

Amount of Claim: [Amount of Claim]

Dear [Personalize],

I am writing on behalf of my patient, [Patient full name], to appeal a [prior authorization / claim] denial and request your reconsideration of coverage for ZYNLONTA™ (loncastuximab tesirine-lpyl).

After review of the documentation, I understand that [health plan name] has denied this [prior authorization / coverage request] on [date of service] for the following reasons:

[Insert reasons provided in denial letter and attach documentation]

Based on my medical expertise, I respectfully request that [health plan representative name] reconsider its decision and [provide authorization / payment] for ZYNLONTA™. I have provided additional information below in support of this request.

[Patient name]’s medical history and previous and current treatment is consistent with the following:

* [Information on patient’s current medical condition, (for example, diagnosis, test results, symptoms)
* All previous and current treatment regimens, including any treatment outcomes
* Patient’s medical prognosis
* Other supporting information (USPI, guidelines, HCP office-selected clinical notes)]

Treatment with ZYNLONTA™ [has been / is] a necessary therapy for this patient’s medical condition, and it is my clinical opinion and assessment that [Patient name] [has benefited / can benefit] from ZYNLONTA™. The enclosed information, along with my medical recommendations, will establish the necessity for [prior authorization / payment of this claim].

Please call my office at [insert telephone number] if I can provide you with any additional information to approve my request. I look forward to receiving your timely response and approval of this request.

Sincerely,

[Physician’s name, degree[s], and signature]

Enclosures: [Include enclosures, such as relevant medical records, USPI, and FDA approval information]