

Sample Letter of Appeal Outline

Use of this document does not guarantee coverage of the medication for your patient. Rather, this document is intended to provide you with examples of the type of information that is typically required when appealing a denial of coverage.

The contents of your letter must be based on your medical judgment and align with the patient's medical records. Text shown in bold below is intended for guidance only, and should be replaced with appropriate patient-specific information before sending your customized letter to your patient's insurance provider.

Date
Name of insurance company
Insurance street address
City, State, ZIP code

RE: Request for reconsideration of use of Bevyxxa® (betrixaban) oral capsules for **Patient Name**
Member ID: **Patient ID number**
Date of Birth: **Patient date of birth**
Group or Medicare Number: **Patient group/Medicare number**
Rx Bin Number: **Patient Rx Bin number**
Claim or Explanation of Benefit Number: **Reference number for denied claim**

To whom it may concern:

I am writing on behalf of my patient, **patient name**, to appeal your denial of coverage for use of Bevyxxa® (betrixaban). The above claim was denied as **denial reason, e.g. not medically necessary, not covered on the formulary, etc., as provided by insurance company**. We are requesting reconsideration of the denial of coverage for Bevyxxa. Bevyxxa is indicated for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE and is medically necessary and appropriate for my patient.

Patient History and Diagnosis
Outline the patient's medical history, diagnosis and treatment plan. Provide rationale for selecting Bevyxxa for extended-duration VTE prophylaxis.

Patient Name is a/an **age**-year-old **male/female** who has been admitted to our hospital for treatment of **disease** since **date** and will require a venous thromboembolism (VTE) prophylaxis agent after discharge.

Bevyxxa is medically appropriate for my patient for the following reasons:

- **Insert treatment rationale as to why Bevyxxa is medically appropriate**
- **Insert description of patient's situation to explain why patient is considered to be at risk of VTE, requiring VTE prophylaxis**
- **Insert explanation for why other treatment options are not appropriate or available and why you have chosen to prescribe Bevyxxa for your patient**
- **Summary (your professional opinion) about the likely outcome of failure to initiate or continue VTE prophylaxis with Bevyxxa**

To support my appeal, I have enclosed the following documentation for your review:

- Denial letter from prior authorization request
- Supportive medical records
- Documentation of risk factors
- Prescribing information or package insert for Bevyxxa® (betrixaban)
- **Additional information, including published clinical trial results**

It is crucial that **insurance company** provide coverage for Bevyxxa for this patient, as this intervention is medically appropriate.

Kindly contact me at **insert telephone number** if you need any additional information or would like to discuss this further. Thank you for your prompt attention and consideration of this matter and for your anticipated approval of Bevyxxa for extended-duration VTE prophylaxis of **Patient Name**.

Sincerely,

Treating Provider Name