INFORM: SAMPLE LETTER OF MEDICAL NECESSITY

Dear <PRESCRIBER NAME and TITLE>

Included below is language you may use when preparing a letter of medical necessity to your patient's insurer when appealing a denial of coverage. This language is only an example of what some insurance plans may consider relevant information when making a coverage determination. Please do not submit the template itself. You should use this to help you create your own letter on your letterhead. You should always use your professional judgment, provide accurate clinical information, and consider the specific requirements of the patient's plan when preparing letters of medical necessity and other appeal information. Please note that insurance plans vary and may require different or additional information when considering access to TAVNEOS® (avacopan).

{Date Created}

{Prescriber Full Name and Title}
{Street Address}
{City, State and Zip Code}

{Payer Contact Name and Title} (Usually the Medical Director)
{Name of Health Insurance}
{Street Address}
{City, State and Zip Code}

Insured: *{Patient Name}*
DOB: *{Patient DOB}*
Member ID: *{Member ID}*
Group Number: *{Group Number}*

Dear Dr. *{Medical Director's Name}*,

I am writing on behalf of my patient *{Patient Full Name}* to request TAVNEOS (avacopan) coverage. You have concluded that *{Patient First Name}*'s plan does not currently cover TAVNEOS. However, it is my professional opinion as a *{Prescriber Specialty}* that it is medically necessary for him/her. *{Patient First Name}* has been under my care since *[date]* for the treatment of *{Diagnosis}.*

Please review my clinical rationale and the attached documentation to assist with your coverage decision.

- *Consider including:*
    - *rationale for why this is medically necessary*

- *any pertinent diagnostic results*
- *previous or current therapies which may be relevant*
- *reasons to substantiate why this is the next logical step in your medical judgment to help the patient manage their disease*
- *any applicable medical records which support your decision to prescribe TAVNEOS*
- *published data you feel supports the use of TAVNEOS for the patient's condition*
- *any other relevant considerations*

Based upon the clinical rationale included, I am requesting your approval of TAVNEOS as appropriate and medically necessary for my patient. If any further information is required to approve this request, please call me at *{Prescriber's phone number}* to discuss.

Thank you in advance for your immediate attention to this request so I may move forward with treating this patient as I deem necessary for their health.

Sincerely,

{Prescriber's Signature}

{Prescriber's Name and Title}