Instructions
This sample letter of appeal is offered as a resource for healthcare professionals to use when appealing a prior authorization denial for patients.

Along with the letter, please include the following attachments to support the appeal:

- Original claim form
- Copy of denial or explanation of benefits
- Any other additional supporting documents

Use of the letter does not guarantee that the insurance company will provide reimbursement for TG Therapeutics' medicines, and is not intended to be a substitute for, or an influence on, the independent medical judgment of the healthcare provider. There is no requirement that any patient or healthcare provider use any TG Therapeutics product in exchange for this information.

Sample Letter of Appeal
(Healthcare Provider Letterhead)

[Date]
[Payer Name]
[Payer Address]
[City, State, ZIP Code]
[Payer Phone and Fax Number]

Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Member Identification Number: [Member Identification Number]
Group Number: [Number]
Claim Number: [Number]

Dear **[Appeals Department, Insurance Company, or Contact]**:

I am writing on behalf of my patient, [Patient Name], to appeal [Name of Health Insurance Company]'s decision to deny coverage for UKONIQ™ (umbralisib), which I prescribed for the treatment of [diagnosis and ICD-10-CM code]. 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]

I believe that [Patient Name] would benefit from UKONIQ based on the following supporting information.

Patient History and Diagnosis
[Insert brief description of the patient's medical condition here]
[Insert short summary of the patient's medical history (eg, lab results, failed medicines, as applicable)]

Rationale for Treatment
[Explain why UKONIQ is the most clinically appropriate option for this patient]
Considering the patient's history, condition, and the full Prescribing Information supporting uses of UKONIQ, I believe treatment with UKONIQ at this time is warranted, appropriate, and medically necessary, and should be a covered and reimbursed service.
[Describe the potential consequences to the patient if they do not receive this medicine]
[Obtain and attach supporting letters of medical necessity from any specialist who is or has provided care to the patient]
[Include diagnosis and ICD-10-CM code]
[Include prescribed dosage of UKONIQ]
[Medical literature regarding the use of UKONIQ for diagnosis; ICD-10-CM code]

Based on the information provided above and enclosed, we hope you agree that the use of UKONIQ is medically appropriate and necessary for [Patient Name] and consider overturning your coverage decision regarding UKONIQ for [Patient Name]. Thank you for your prompt attention to this matter. I look forward to your reconsideration. If I can provide any additional information, please contact me.

Thank you in advance for your immediate attention to this written appeal.

Sincerely,

[Physician's Name]
[Physician NPI Number]
[Physician's Practice Name]
[Physician's Practice Address]
[City, State, ZIP Code]
[Physician Phone and Fax Number]

Enclosures
[Include prescribing information for the prescribed medication]
[Medical literature regarding the use of UKONIQ for diagnosis; ICD-10-CM code]
[Relevant clinical documentation, such as history and physical, progress notes, treatment history]
[Include other relevant references and publications regarding medicine]