[Physician letterhead]

[Date]
[Health plan name]

ATTN: [Prior authorization department]
[Contact name (if available)]
[Health plan address]
[City, State ZIP]

Re: Appeal for Denial of INFUGEM™ (gemcitabine in a 0.9% sodium chloride injection), 10 mg/mL

[Patient name]
[Date of birth]
[Insurance ID number]
[Insurance group number]
[Case ID number]
[Dates of service]

Dear [Contact name],

This letter is sent on behalf of [patient's name] to request an appeal of a denied prior authorization for INFUGEM™. According to the denial letter, [name of health plan] denied this prior authorization because [include reason from denial letter]. I am asking that you reconsider your denial of coverage for INFUGEM™ for the treatment of [cancer diagnosis and medical billing code] for [patient's name].

INFUGEM™ [dose, frequency] is the appropriate therapy for [patient's name]. [Patient's name] has [specify cancer type and classification.] [Provide a brief summary of current condition, past treatments, contraindications for other therapies, and any sensitive areas involved.]

Enclosed you will find additional documentation with relevant clinical history for [patient's name], including diagnosis, current condition, and symptoms. Using INFUGEM™ for my patient is based on [provide a clinical rationale for the use of INFUGEM™ in this clinical case].

[Indicate here if the patient is immunocompromised, has renal or hepatic impairment, has recently received radiation therapy, is a male/female of reproductive potential, or is pregnant.] I am attesting that my patient [does/does not] have [any of the conditions mentioned in the previous statement].

[If the patient has any of the conditions mentioned above, please list them.]

[Provide any other information that in your professional medical judgment is relevant, including but not limited to a brief summary of the patient's history and current condition (eg, any previous treatments, contraindications for other treatments, and what factors led you to recommend the use of INFUGEM™).]

Please contact my office by calling [physician's phone number] for any additional information you may require in support of this appeal. I look forward to your timely approval.

Sincerely,
[Physician's signature]
[Physician's name]

[List additional documents, which may include package insert for INFUGEM™, copy of patient's medical records, diagnostic forms and photos of affected areas, or other supporting documentation.]