

[Date]
[Health plan name]

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

Re: Appeal for Denial of DRIZALMA SPRINKLE™ (duloxetine delayed-release capsules)

[Date of birth]
[Insurance ID number]
[Insurance group number]
[Case ID number]
[Date 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 Drizalma Sprinkle™. According to the denial letter, [name of health plan] denied this prior authorization because [reason from denial letter]. I am asking that you reconsider your denial of coverage for Drizalma Sprinkle™ for the treatment of [x] [ICD-10 code] for [patient's name]. Treatment with Drizalma Sprinkle™ [dose, frequency] is medically appropriate and necessary for this patient.

[Patient's name] is a [age]-year-old [gender] who was diagnosed with [x] on [date]. [Patient's name] has been in my care since [date].

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

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

Please contact my office by calling [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]

Suggested enclosures:
Copy of denial letter
Package insert for Drizalma Sprinkle™ Medication records
Clinical records that support the need for Drizalma Sprinkle™
Other supporting documentation

PM-US-DRI-0009 09/2019