

Sample Letter of Appeal for Monoferriic

This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when seeking an appeal of coverage denial from a patient's insurance company. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence, the independent clinical decision of the prescribing healthcare professional.

[Physician or Practice Letterhead]

[Date]

[Health Plan Name]

ATTN: [Department]

[Medical Director Name]

[Health Plan Address]

[City, State ZIP]

RE: Patient Name _____
Date of Birth _____
Policy Number _____
Claim Number _____

Re: Letter of Appeal for Monoferriic® (ferric derisomaltose)

Dear **[Medical Director Name]**,

My name is **[Physician Name]** and I am a **[board-certified medical specialty] [NPI]**. I am writing this letter to provide additional information to support my request to treat **[Patient Name]**, who has been diagnosed with **[condition]**, **[ICD code(s)]**, with Monoferriic, an iron replacement product indicated for the treatment of iron deficiency anemia (IDA) in adult patients who have intolerance to oral iron or have had unsatisfactory response to oral iron and/or who have non-hemodialysis dependent chronic kidney disease.

In brief, treating **[Patient Name]** with Monoferriic is medically appropriate and necessary and should be a covered and reimbursed service. **[Health Plan Name]** determined Monoferriic was not covered for **[Patient Name]** because **[reason(s) for denial]**. This letter provides my clinical rationale and relevant information about the patient's medical history and treatment.

Summary of Patient's History

[Must include: Patient's clinical / medical history, diagnosis, condition, and symptoms:]

[Patient Name] is **[a/an]** **[age]**-year-old **[male/female]** patient who has been diagnosed with **[condition]****[ICD-10-code(s)]** as of **[date of diagnosis]**. **[He/she]** has been in my care since **[date]**.

[Include any additional considerations here:]

My rationale for prescribing Monoferriic is based on **[include a brief disease course of patient, including history of disease, laboratory results, symptoms, and previous treatments (including names, dosages, frequency, and length)]**. If the patient has discontinued treatment, please include information on the reasons for such discontinuation, such as inability to tolerate a previous treatment, lack of response and or side effects, e.g. You may also want to include medical reasoning for choosing to bypass any

alternative medications preferred by the health plan such as COVID-19 risk exposure due to multiple infusions, patient may not be able to comply with labeled multiple dosing requirements of preferred products over an extended period of time, and treatment guidelines such as NCCN, KDIGO, and NICE.]

[Please exercise your medical judgment and discretion when providing diagnosis and characterization of the patient's medical condition].

Based on the patient's condition and medical history, as well as my experience treating patients with IDA, I believe treatment with Monoferric is warranted, appropriate, and medically necessary in this case. The accompanying package insert provides the approved clinical information for Monoferric. I have attached relevant lab test analyses and medical records to support my decision.

I am requesting an immediate and expedited review of this appeal by a board certified and specialty matched physician who can render a decision based upon the standards of care outline above. If you have any further questions about this matter, please contact me at **[Physician Phone Number]** or via e-mail at **[Physician Email]**. I look forward to receiving your timely response and approval of this claim.

If you do not feel that the information provided has established medical necessity, please provide me with your detailed rationale based upon the standards of care, the specialty of the physician who reviewed this case, and whether they are board certified in an applicable medical specialty.

Sincerely,

[Physician name]

[Physician signature]

[Physician address]

[Physician phone number]

Enclosures

[List enclosures, which may include the explanation of benefits/denial letter, copies of original claim form, clinical notes/diagnostic report, medication records, relevant laboratory reports that support the need for Monoferric, Monoferric Prescribing Information, and other supporting documentation].