AAA PatientCONNECT™ has become Novartis Patient Support

Novartis Patient Support

Phone: 1-844-638-7222 | Fax: 1-844-638-7329

SAMPLE LETTER OF APPEAL - This sample is provided for informational purposes only and does not replace the physician's independent medical judgment. Use of this sample is not a guarantee of reimbursement.

Instructions: Follow individual payers' requirements for preparing and submitting appeals. Although this Sample Letter template is provided as a potential resource as part of an appeal process, it does not replace the HCP's independent medical judgment or cover every payer-specific requirement. Providers are responsible for customizing the letter to reflect the unique background and diagnosis of a particular patient, as well as the special requirements of the particular payer involved. The provider is responsible for ensuring the medical necessity of the procedure.

Recommended Attachments: (original claim form, copy of denial or explanation of benefits [if applicable], copy of patient's insurance card, LUTATHERA Prescribing Information, FDA approval letter, and any additional information the HCP deems appropriate)

DATE

PAYER NAME

PAYER ADDRESS 1

PAYER ADDRESS 2

PAYER CITY STATE ZIP

PAYER FAX NUMBER

Attn: _____
APPEALS DEPARTMENT

RE: _____
INSERT PATIENT NAME

Date of Birth: _____
INSERT PATIENT'S DOB

Policy ID/Group Number: _____
INSERT POLICY ID/GROUP NUMBER

Plan Number: _____
INSERT PLAN NUMBER

Policy Holder: _____
INSERT POLICY HOLDER'S NAME

Date of Service: _____
INSERT DATE OF SERVICE

Claim Number: _____
INSERT CLAIM NUMBER

To Whom It May Concern:

I am requesting an expedited appeal for medically necessary services prescribed to _____ (INSERT PATIENT NAME) for therapy with LUTATHERA® (lutetium Lu 177 dotatate) injection for intravenous use on _____ (DATE OF SERVICE).

_____ (NAME OF HEALTH INSURANCE COMPANY) denied a claim in the amount of _____ (DOLLAR AMOUNT OF CHARGES) on _____ (DATE(S) OF SERVICE) due to _____ (SUMMARIZE INSURER'S STATED REASON FOR CLAIM DENIAL).

LUTATHERA is indicated for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs), including foregut, midgut, and hindgut neuroendocrine tumors in adults.

Because _____ (NAME OF PATIENT) has been diagnosed with _____ (PATIENT'S DIAGNOSIS) as of _____ (DATE OF DIAGNOSIS), and _____ (PROVIDE A BRIEF DISCUSSION OF PATIENT'S RELEVANT MEDICAL HISTORY, CONDITION/SYMPTOMS AND THERAPY TO DATE, INCLUDING OTHER TREATMENTS ATTEMPTED AND RESULTS).

I believe LUTATHERA is medically necessary and a clinically appropriate treatment for _____ (NAME OF PATIENT).

Thank you, in advance, for your review and consideration of this appeal. If you have any questions or require additional information regarding this case, please contact me at _____ (PHYSICIAN'S TELEPHONE NUMBER).

Sincerely,

_____ (PHYSICIAN'S NAME) _____ (PHYSICIAN'S SIGNATURE)

_____ (CONTACT INFORMATION)

NOVARTIS

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One Health Plaza
East Hanover, New Jersey 07936-1080