**LETTER OF APPEAL**



**Note:** This example is for instructional use only. Use the form provided by the payor, if available.

Date Contact name Company name Phone Fax

**Include all insurance company information, including the contact information for the representative.**

Appeal for coverage of VENTAVIS® (iloprost) Inhalation Solution 2.5 mcg with 10 mcg/mL, 5.0 mcg with 10 mcg/mL, 5.0 mcg with 20 mcg/mL

**Include all patient information, including health insurance policy details.**

Subscriber name: Name of insured: Policy number: DOB:

Reference ID, if available:

Prescriber name: Prescribed on: Phone number: Fax number:

**Include your information, including contact details.**

Dear [*Claims Representative*]:

I am writing to request a review of a denied claim for [*Patient name*]. Your company has denied this claim for the following reason(s): [*Fill in reason(s) from Explanation of Benefits (EOB)*].

**Cite reasons from payor response.**

[*Patient name*] was provided VENTAVIS® (iloprost) Inhalation Solution therapy for the treatment of pulmonary arterial hypertension (PAH, WHO Group 1), defined as mean pulmonary arterial pressure ≥25 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, pulmonary vascular resistance >3 Wood units.

VENTAVIS Inhalation Solution is indicated for the treatment of PAH (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH (65%) or PAH associated with connective tissue diseases (23%).

**Consider including indication.**

[*Patient name*] is diagnosed with PAH (WHO Group 1). [*Include any supporting documentation to address the reasons for denial. This could include test and lab results, hospital admission information, or a list of ineffective, intolerant, or contraindicated treatments.*]

**Respond to reasons for denial.**

[*Please summarize the clinical rationale for prescribing* VENTAVIS *for this patient. Additionally, consider providing the treatment plan, patient prognosis, and any other pertinent medical information to support why* VENTAVIS *is medically necessary for this patient.*] I trust that the enclosed information, along with my medical recommendations, will establish the medical necessity for payment of this claim.

**Summarize medical necessity.**

Sincerely, [*Doctor name*]

**Enclosures:** [*List enclosures such as EOB, denial letter, Prescribing Information, clinical evidence, or lab reports*]

*Actelion Pathways* is a registered trademark of Actelion Pharmaceuticals Ltd



VENTAVIS is a registered trademark of Bayer Intellectual Property GmbH, used under license by Actelion Pharmaceuticals US, Inc.

© 2018 Actelion Pharmaceuticals US, Inc. All rights reserved. VEN-00239 0718