**Example #6**

**Sample Appeal Letter for Claims Denial**

*This letter provides an example of the types of information that may be provided when appealing a claims denial from a patient’s health plan for EYLEA® (aflibercept) Injection treatment.*

*Use of the information in this letter does not guarantee that the health plan will provide reimbursement for EYLEA and is not intended to be a substitute for or an influence on the independent medical judgment of the physician.*

*A copy of the full Prescribing Information for EYLEA is available for download on* [*www.EYLEA.com*](http://www.EYLEA.com)*.*

**Some Key Reminders:**

• Use an appeal letter when reimbursement for a claim is underpaid or denied

• The appeal letter should come from a treating physician and should be signed by **both** the physician and patient

• Refer to the ICD-10 Coding Guidelines [here](http://hcp.eylea.us/reimbursement-and-patient-support/icd10-code-finder.php#step-1) regarding certain codes that may be applicable to the patient’s diagnosis

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**EXAMPLE**

[Date]   
[Plan name]

[Plan street address]   
[Plan city, state, zip code]

Dear **[contact name]**:

Re: [Patient full name]

Date of Birth [Patient date of birth]

Member ID [Patient ID number]

Group Number [Patient group number]

I am writing on behalf of my patient, **[Patient Full Name]**, to request reconsideration of coverage for   
EYLEA® (aflibercept) Injection, which was administered on **[Date(s) of service]**. Reimbursement was **[denied] [underpaid]** because **[state reason given in denial letter]**. I will explain why this claim should be reimbursed and EYLEA should be fully covered for **[Patient Full Name]**. I have included information about the patient's medical history and diagnosis (ICD-10 code: **[insert code]**), a statement summarizing my treatment rationale, and other documents that support the medical necessity of EYLEA in this clinical case.

Since **[Date of Onset]**, **[Patient Full Name]** has been under my care for

**[Neovascular (Wet) Age-related Macular Degeneration (AMD)]**

**[Macular Edema following Retinal Vein Occlusion (RVO)]**

**[Diabetic Macular Edema (DME)]**

**[Diabetic Retinopathy (DR) with Diabetic Macular Edema (DME)**]

**Summary of Patient History**

* **[Treatment history]**
* **[Response to past therapies]**
* **[Recent symptoms and condition]**

**[Summarize your professional opinion of the patient’s likely prognosis or disease progression with and without treatment with EYLEA.]**

Based on the patient’s clinical condition and a review of the supporting documentation, I am confident you will agree that EYLEA, which is explicitly indicated for this condition, was the appropriate treatment option. In order for me to provide appropriate care for my patient, it is important that **[Plan Name]** reimburse our claim and provide adequate coverage for EYLEA moving forward. I would appreciate prompt review of this case.

On behalf of **[Patient Full Name]**, we appreciate your reconsideration. Please call me at **[Phone Number]** if I can be of further assistance or if you require additional information. Thank you in advance for your immediate attention to this request.

Sincerely,

*[Treating physician’s signature] [Patient/Legal representative signature]*

[Treating physician’s name, MD/DO] [Patient/Legal representative name]

**Enclosures** (suggested): Appeal form (if provided by the plan)  
Chart notes  
Test results  
Supporting medical studies   
EYLEA Prescribing Information  
Patient narrative