

Instructions:

This template is offered as a resource for a healthcare provider to potentially use when responding to a denial for coverage from a patient's insurance company for Rezdifra™ (resmetirom) and/or for explanation of medical necessity.

Attachments to be included with the appeal letter are <original claim form, copy of denial or explanation of benefits, and any other additional supporting documents.> If you need additional references, please contact our medical information team at 1-800-905-0324.

The use of the letter does not guarantee that the insurance company will provide coverage for Rezdifra™ (resmetirom) and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Appeal

(Healthcare Provider Letterhead)

Date: [Date]

Payer Name: [Payer Name]

Payer Address: [Payer Address]

City, State, ZIP Code: [City, State, ZIP Code]

Payer Phone: [Payer Phone]

Payer Fax: [Payer Fax]

Patient Name: [Patient Name]

Patient Date of Birth: [Patient Date of Birth]

Policy Number: [Policy Number]

Group Number: [Number]

BIN Number: [Number]

Dear [Name of the appropriate person at the insurance company]:

I am writing on behalf of my patient, [Patient Name], to appeal [Name of health insurance company]'s decision to deny coverage for Rezdifra™ (resmetirom), <indication>. It is my understanding based on your letter of denial dated [Date], that coverage has been denied for the following reason(s): [List the specific reason(s) for the denial as stated in the denial letter.] This letter provides information about the patient's medical history and diagnosis, along with a statement summarizing my treatment rationale.

Patient History and Diagnosis

[Provide a brief description of the patient's medical condition]

[Include a short summary of the patient's medical history including lab results and failed medicines, as applicable]

[Explain why you believe it is medically necessary for the patient to receive Rezdifra™ (resmetirom)]

[Describe the potential consequences for the patient if they do not receive Rezdifra™ (resmetirom)]

[Obtain and attach supporting letters from any other specialist(s) that is currently or has previously provided care to the patient]

[Include Rezdifra™ (resmetirom) indication information]

[Include Rezdifra™ (resmetirom) administration information]

To conclude, Rezdifra™ (resmetirom) is medically necessary for this patient's medical condition. Thank you in advance for your immediate attention to this written appeal.

Sincerely,

[Physician's Name]

Physician Signature: _____

[Physician's practice name, address, phone number]

References

[Include Rezdifra™ (resmetirom) Prescribing Information]

[Include other relevant references and publications regarding Rezdifra™ (resmetirom)]

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