

Sample Letter of Appeal

Please Note: The following is a template for MYCAPSSA® (octreotide) that your office can customize based on your patient's medical history. These materials are available for download and public personal use. These materials have no monetary value and are not to be re-sold or repurposed. They are solely for your personal use. No purchase from or relationship with Chiesi is required to download or use these materials. Chiesi makes no representations or warranties about these materials or their fitness for any specific use. Chiesi is not responsible for any changes made to these template documents. It is the sole responsibility of the health care provider to include the proper information and ensure the accuracy of all statements used in seeking coverage and reimbursement for an individual patient. All billing and coding decisions are the responsibility of the relevant physician. Chiesi makes no guarantee regarding coverage or reimbursement.

Using this template:

- Fill in the template using the instructions highlighted in **magenta**.
- Once you have filled in the information, remove any remaining instructions in **magenta**.
- Select all the text and change the font to black so the whole document appears as one letter.

Use the steps above as a checklist to make sure you have completed these steps prior to sending. **It is important to follow these steps to ensure the letter is clear and concise.**

Attention:
[Contact name]
[Insurance company name]
[Insurance company street address]
[Insurance company city, state ZIP]

Re: [Insured patient name]
Date of birth: [Patient date of birth]
Policy number: [Policy 4*]
Group number: [Group 4*]

Subject: Letter of appeal to treat with MYCAPSSA® (octreotide) delayed-release oral capsules

To Whom It May Concern:

I am requesting reconsideration of your denial for the [continued] use of MYCAPSSA® (octreotide) [Insert Dose] for my patient, [Patient Name, ID#, Group #]. MYCAPSSA delayed-release capsules, for oral use, is a somatostatin analog indicated for long- term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide.

Treatment Rationale:

Based on my clinical judgment, MYCAPSSA is medically necessary for [Patient name] because [Provide information on patient response and history to past treatments and anticipated prognosis and rationale for the currently prescribed product].

Medical Record Information:

[Patient name] is a [age]-year-old [male/female] who suffers from acromegaly (ICD-10 code E22.0). [He/She] [has tried and failed the following medications: (list medications)].

Outline of Medical Studies:

MYCAPSSA is an FDA-approved oral somatostatin analog indicated for long term maintenance treatment in acromegaly patients who have responded to and tolerated treatment with octreotide or lanreotide. [Consider inserting a summary of evidence, such as clinical study results, demonstrating outcomes in the condition and/or patient population].

It is my clinical opinion and assessment that [Patient name] will benefit from [the continuation of] this regimen. I trust the information presented, along with my medical recommendations, will establish the medical necessity for payment of this claim.

Sincerely,

[Physician Name and Signature]
[Phone Number]

Reference: MYCAPSSA [package insert]. Chiesi USA, Inc. 2024.

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