LETTER OF APPEAL

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

ACTELION Pathways®

Date _____

Contact name _____

Company name _____

Phone _____

Fax _____

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

Appeal for coverage of OPSUMIT® (macitentan) 10 mg

Subscriber name: _____

Name of insured: _____

Policy number: _____

DOB: _____

Reference ID, if available: _____

Include all patient information, including health insurance policy details.

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 OPSUMIT® (macitentan) 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.

OPSUMIT is an endothelin receptor antagonist (ERA) indicated for the treatment of PAH (WHO Group 1) to delay disease progression. Disease progression included: death, initiation of intravenous (IV) or subcutaneous prostanoids, or clinical worsening of PAH (decreased 6-minute walk distance, worsened PAH symptoms and need for additional PAH treatment). OPSUMIT also reduced hospitalization for PAH.

Consider including indication.

Effectiveness was established in a long-term study in PAH patients with predominantly WHO Functional Class II-III symptoms treated for an average of 2 years. Patients were treated with OPSUMIT monotherapy or in combination with phosphodiesterase-5 inhibitors or inhaled prostanoids. Patients had idiopathic and heritable PAH (57%), PAH caused by connective tissue disorders (31%), and PAH caused by congenital heart disease with repaired shunts (8%).

[*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* OPSUMIT *for this patient. Additionally, consider providing the treatment plan, patient prognosis, and any other pertinent medical information to support why* OPSUMIT *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*]

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