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 TRACLEER® (bosentan) tablets 62.5 mg, 125 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 TRACLEER® (bosentan) tablets 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.

TRACLEER is indicated for the treatment of PAH (WHO Group 1) to improve exercise ability and to decrease clinical worsening. Studies establishing effectiveness included predominantly patients with NYHA Functional Class II-IV symptoms and etiologies of idiopathic or heritable PAH (60%), PAH associated with connective tissue diseases (21%), and PAH associated with congenital heart disease with left-to-right shunts (18%). **Considerations for use:** Patients with WHO class II symptoms showed reduction in the rate of clinical deterioration and a trend for improvement in walk distance. Physicians should consider whether these benefits are sufficient to offset the risk of hepatotoxicity in WHO class II patients, which may preclude future use as their disease progresses.

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