

# LETTER OF APPEAL

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



Date \_\_\_\_\_  
Contact name \_\_\_\_\_  
Company name \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_

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

Appeal for coverage of VENTAVIS® (iloprost) Inhalation Solution 2.5 mcg with 10 mcg/mL, 5.0 mcg with 10 mcg/mL, 5.0 mcg with 20 mcg/mL  
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 VENTAVIS® (iloprost) Inhalation Solution therapy for the treatment of pulmonary arterial hypertension (PAH, WHO Group 1), defined as mean pulmonary arterial pressure  $\geq 25$  mmHg, pulmonary arterial wedge pressure  $\leq 15$  mmHg, pulmonary vascular resistance  $> 3$  Wood units.

VENTAVIS Inhalation Solution is indicated for the treatment of PAH (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration. Studies establishing effectiveness included predominantly patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH (65%) or PAH associated with connective tissue diseases (23%).

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