*This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when responding to a request from a patient’s insurance company for an appeal of coverage. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for or to influence the independent clinical decision of the prescribing healthcare professional.*

**[Date]**

ATTN: **[Name of Contact or Medical Review/Appeals]**

**[Name of Health Insurance Company]**

**[Street Address]**

**[City, State, ZIP code]**

Insured: **[Patient First and Last Name]**

Policy Number: **[Policy Number]**

Group Number: **[Group Number]**

RE: IWILFINTMClaim Denial

Dear **[Name of Contact]**,

This is a formal letter of appeal for reconsideration of coverage on behalf of my patient, **[Patient Name],** for IWILFINTM(eflornithine) tablets, which is indicated for the treatment of **[Disease]**. **[Insurance Company]** has stated that IWILFINis not covered because **[Denial Reason].** I am requesting prompt reevaluation of the claim denial for IWILFIN provided to my patient on **[Date(s) of Service].**

**Clinical History** *Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition. You may want to include the following information, as applicable.*

* Brief description of patient’s age, diagnosis, prior treatments, and response to treatments
* Presentation, comorbidities, and other factors that impact the treatment decision

**Rationale for IWILFIN**

The FDA has approved IWILFIN (eflornithine) to reduce the risk of relapse in adult and pediatric patients with high-risk neuroblastoma (HRNB) who have demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy. According to the explanation of benefits (EOB), **[Name of insurer/Medicare contractor]** denied this claim because **[insert reason, as stated on EOB, for denial]**. This letter serves to request a formal appeal of claim **[Claim Number]** for **[Patient Name]**, with policy number [**Policy Number**].

**[Explain why IWILFIN was selected for the patient]**

Sincerely,

**[Treatment Provider’s Signature]**

**[Treatment Provider’s Name Printed]**

**[Treatment Provider’s Phone Number]**

Enclosures: (Suggested)

**[Explanation of Benefits/Denial Letter]**, **[Copy(ies) of original claim form]**, **[Prescribing information for IWILFIN]**, **[Clinical notes]**, **[Medication records including dates of prior therapy]**, **[Other supporting documentation]**