**Sample Format: Letter of Appeal**

[Insert onto physician letterhead]

|  |  |
| --- | --- |
| [Medical Director]  [Insurance Company]  [Address]  [City, State ZIP] | **RE:** **Member** **Name** [Insert Member Name]  **Member Number** [Insert Member Number]  **Group Number** [Insert Group Number] |

Dear [Insert Name of Medical Director]:

I am writing to ask for a reconsideration of my request for the approval of [insert patient name] with UPTRAVI® (selexipag) for the treatment of pulmonary arterial hypertension (PAH, WHO Group I), defined as mean pulmonary arterial pressure >20 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, and pulmonary vascular resistance >2 Wood units.

UPTRAVI® is indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to delay disease progression and reduce the risk of hospitalization for PAH. Effectiveness was established in a long-term study in PAH patients with WHO Functional Class II-III symptoms. Patients had idiopathic and heritable PAH (58%), PAH associated with connective tissue disease (29%), PAH associated with congenital heart disease with repaired shunts (10%).

In brief, treatment with UPTRAVI® is medically appropriate and necessary and should be a covered therapy for my patient.

[Insert plan name] has denied coverage of UPTRAVI® for [insert patient’s name]because [insert reason for denial as indicated on the explanation of benefits]. The following rationale supports my decision to prescribe UPTRAVI® and outlines [insert patient name]’s medical history, prognosis, and my treatment rationale.

[In my judgment, [Product X] is not a medically appropriate treatment for [insert patient name] because he/she has [insert rationale, eg, personal medical history of/family history of X condition, contraindication, comorbid condition, prior inadequate response, or an adverse reaction to Product X].]

**Summary of Patient’s History and Treatment Rationale**

[Insert summary of patient history and diagnosis per your medical judgment. You may want to include:

* Previous therapies/procedures and the patient’s response to those interventions
* Previous treatment of PAH including UPTRAVI®, if applicable, and patient’s response
* Brief description of the patient’s recent condition and test results (eg, right heart catheterization, acute vasoreactivity, echocardiography, functional class, oxygen use, or 6-minute walk distance)
* History of patient’s routine and non-routine visits, including ED if applicable
* Summary of your professional opinion of the patient’s likely prognosis without treatment with UPTRAVI®
* Summary of your credentials in treating PAH
* Your goals of PAH treatment

Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

Given the patient’s history, condition, and the published data supporting the use of UPTRAVI®, treatment of [insert patient name]with UPTRAVI® is warranted, appropriate, and medically necessary.

The attached copies of [clinical peer-reviewed literature, full Prescribing Information, etc] document that UPTRAVI® is an appropriate treatment option for this patient. If you disagree with coverage and uphold this denial, I will request that a pulmonologist or cardiologist review this documentation.

I look forward to receiving your timely response and approval of this request.

Sincerely,

[Insert doctor’s name, contact information, and participating provider number]

**Please see full Important Safety Information for** [**UPTRAVI®**](https://uptravihcp.com/uptravi-important-safety-information/)**.**

Enclosures: [list enclosures such as explanation of benefits, denial letter, Prescribing Information, clinical evidence, or test results/lab reports].

© 2022 Actelion Pharmaceuticals US, Inc. cp-147019v2 10/22