**Sample Format: Letter of Appeal**

[Insert onto physician letterhead]

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| --- | --- |
| [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 treatment of [insert patient name] with OPSUMIT® (macitentan) for the treatment of pulmonary arterial hypertension (PAH, WHO Group I), defined as mean pulmonary arterial pressure ≥25 mmHg, pulmonary arterial wedge pressure ≤15 mmHg, and pulmonary vascular resistance >3 Wood units.

OPSUMIT is an endothelin receptor antagonist (ERA) indicated for the treatment of pulmonary arterial hypertension (PAH, WHO Group I) to reduce the risks of disease progression and hospitalization for PAH. 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 had idiopathic and heritable PAH (57%), PAH caused by connective tissue disorders (31%), and PAH caused by congenital heart disease with repaired shunts (8%).

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

[Insert plan name] has denied coverage of OPSUMIT 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 OPSUMIT 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 response to these interventions
* Previous treatment of PAH including OPSUMIT, 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
* Hospital admission information, if applicable
* Summary of your professional opinion of the patient’s likely prognosis without treatment with OPSUMIT
* Summary of your credentials in treating PAH
* Your goal to reduce the risk of PAH-related patient hospitalization

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 OPSUMIT, treatment of [insert patient name] with OPSUMIT is warranted, appropriate, and medically necessary.

The attached copies of [clinical peer-reviewed literature, full Prescribing Information, etc] document that OPSUMIT 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]

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

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