Sample Appeal Letter for VABYSMO™ (faricimab-svoa)

Some Key Reminders:

- You may use an appeal letter for a claim (when reimbursement for a claim is underpaid or denied) or when a prior authorization is denied
- Please indicate the type of appeal and the level of appeal for which you are filing
- Include the appropriate ICD-10-CM diagnosis code(s)
- Please ensure the treating physician signs the letter

[Date]

[Payer name]
ATTN: APPEALS
[Payer contact name]
[Payer address]
[City, State ZIP]

Re: Denial for VABYSMO™ (faricimab-svoa)

Patient: [Patient's first and last name]
Date of Birth: [MM/DD/YYYY]
Subscriber ID #: [Insurance ID #]
Subscriber Group #: [Insurance group #]
Case ID Number: [Case ID Number (if available)]
Dates of Service: [Include all denied dates of service]

Dear [Appeals Reviewer],

I am writing to request [a/an] [indicate level of appeal: 1st, 2nd, etc.] [appeal/redetermination/reconsideration] of the above on behalf of my patient, [Patient's first and last name]. I understand from your letter that the [claim/reimbursement] was [denied/underpaid] based on [denial reason(s)]. I would like to address [the reason/those reasons] now. I would appreciate prompt review of the enclosed information demonstrating medical necessity and coverage of VABYSMO™ (faricimab-svoa).

or

I am writing to request [a/an] [indicate level of appeal: 1st, 2nd, etc.] [appeal/redetermination/reconsideration] of the above on behalf of my patient, [Patient's first and last name]. I acknowledge your health plan's policy and I understand from your prior authorization denial letter that the denials were based on [denial reason(s)]. I would like to address [the reason/those reasons] now. I would appreciate prompt review of the enclosed information demonstrating medical necessity and coverage of VABYSMO™ (faricimab-svoa).

Patient's Clinical History

[Patient's first and last name] is [a/an] [age]-year-old [male/female/transgender/etc.] who was diagnosed on [date] with [neovascular (wet) age-related macular degeneration (nAMD) and diabetic macular edema (DME)].

- [Include diagnosis and dates]
- [ICD-10-CM diagnosis codes]
- [Any past treatments]
- [Any test results that indicate failure of past treatment(s)]
- [Extenuating circumstances that would preclude alternatives to VABYSMO]
- [Social and family information]

[REMINDER: If a payer has a published policy, include here.]
[REMINDER: If state statute exists, include here.]

Treatment Plan
[Include plan of treatment (dosage, length of treatment), FDA approval letter, relevant journal articles, clinical studies and clinical practice guidelines that support the use of VABYSMO. Consider mentioning experts in the field who also support the treatment.]

Summary
In summary, I am requesting [a/an] [appeal/redetermination/reconsideration] of the denial(s) of VABYSMO™ (faricimab-svoa) therapy for my patient, [Patient's first and last name]. My patient was diagnosed with [neovascular (wet) age-related macular degeneration (nAMD) and diabetic macular edema (DME)]. I am requesting that you reconsider coverage based on the information above. I am readily available at my office phone [Physician phone number] or via email at [Physician email] to address any questions or concerns you might have regarding this appeal. Thank you for your time and consideration.

Sincerely,

[Physician's name, credentials and signature]

Enclosures
List enclosures, which may include:

- VABYSMO prescribing information
- Clinical notes/medical records
- Diagnostic test results
- Relevant peer-reviewed articles
- FDA approval letter for VABYSMO
- Scans/imaging showing progressive disease
- Pathology reports, if relevant