**SAMPLE LETTER TEMPLATE OF DENIAL APPEAL**
**FOR ASTELLAS PRODUCTS**

**To Prescriber: Please refer to the important safety information in the full Prescribing Information, including any Boxed Warning, when determining whether therapy is medically appropriate for the individual patient.**

[Date]

[Contact Name]
[Insurance Company]
[Insurance Company Address]
[City, State ZIP Code]
[Fax Number]

**ATTN: Prior Authorizations / Appeals**

Re: Coverage of [Astellas Product Name / generic name / dosage form]
[Patient First Name] [Patient Last Name]
[Policy Number]
[Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis]

To whom it may concern:

I am writing to request a review of a denial for coverage of [Astellas Product Name] for [Patient Name]. Your company has denied this claim for the following reasons:

- **[Insert reasons]**

[Patient Name]'s medical history and course of treatment are as follows:

- **[Describe the patient's history, including diagnostic test results, previous and current treatment regimens and their outcomes]**

Based on the information provided above, the use of [Astellas Product Name] is medically appropriate and necessary for [Patient Name]. I have enclosed a copy of the full Prescribing Information for [Astellas Product Name].

I respectfully request that you review the additional documentation provided and consider overturning your coverage decision regarding [Astellas Product Name] for [Patient Name]. Thank you for your prompt attention to this matter. I look forward to your reconsideration. If I can provide any additional information, please contact me.

Regards,

[Physician Name]
[NPI Number]
[Phone Number]
[Fax Number]