<Date>

ATTENTION: <Medical Director Name and/or Medical Review/Appeals>
<Payer Name>
<Payer Address>
<Payer City, State, and Zip>

REGARDING: Denied Claim for **Newly FDA-Approved Dose** of <Product Name> Due to a Medically Unlikely Edit
PATIENT NAME: <Patient's Name>
PATIENT DATE OF BIRTH: <Date of Birth>
LEGAL GUARDIAN OR LEGAL REPRESENTATIVE (if applicable): <Guardian's or Representative's Name>
MEDICARE POLICY ID NUMBER: <Group Number/Policy Number>
DATE OF SERVICE: <Date of Service>

Dear <Medical Director Name and/or Medical Review/Appeals>,

I am writing to appeal the denial of a claim due to a Medically Unlikely Edit (MUE) that is currently in place for <Product Name> and to provide documentation of the medical necessity of <Product Name>.

The case in question involves a patient with <ICD-10 Code> <Diagnosis> with a date of service of <Date of Service>, using the prescribed treatment regimen of <Product Name> <Dose Schedule>. **The US Food and Drug Administration (FDA) recently approved this updated dosing schedule for <Product Name>, as shown in the <enclosed><attached> documentation.**

I have <enclosed><attached> the:

- Prescribing Information for <Product Name> that reflects the updated dosing regimen in Section 2
- Initial claim determination notice

<Rationale for treating the patient with <Product Name>. In this rationale, include a description of the patient's disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

<If the patient has already received treatment with this product, provide a concise but specific description of how this product has benefited the patient. Highlight any documentation that supports your treatment decision.>

In view of the above information, I believe that treatment with <Product Name> <Dose Schedule> is medically necessary and reasonable for this patient's medical condition.

Thank you for taking the time to read this letter.

Sincerely,

<Health Care Provider Signature>
<Health Care Provider Name>
<Health Care Provider Phone Number>
<Health Care Provider E-mail Address>

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