Sample Letter of Appeal—Doptelet® (avatrombopag)

[Instructions for use: Fill in the pink bracketed portions of this letter with the correct relevant information, and remove the Sample Letter heading as well as these instructions prior to use.]

[Date]
[Appeals department]
[Name of health plan]
[Mailing address]

RE: [Patient name]
Policy number: [Policy number]
Treatment requested: Doptelet® (avatrombopag).

Dear [Medical director],

This letter is sent on behalf of [patient's name] to request an appeal of a denied prior authorization for Doptelet® (avatrombopag). According to the denial letter, [name of health plan] denied this prior authorization because [reason from denial letter]. I am asking that you reconsider your denial of coverage for Doptelet for the treatment of chronic ITP [ICD-10 code] for [patient's name].

Treatment with Doptelet is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old [male/female] who was diagnosed with chronic ITP on [date]. [Patient's name] has been in my care since [date].

[List any previous therapies/ procedures, response to those interventions, description of the patient's recent symptoms. Use medical judgement and discretion when providing a description of the patient's medical condition.]

Enclosed you will find additional documentation with relevant clinical history for [patient's name], including diagnosis, current condition, and symptoms. Using Doptelet for my patient is based on [provide a clinical rationale for the use of Doptelet in this clinical case].

Please contact my office by calling [phone number] for any additional information you may require in support of this appeal. I look forward to your timely approval.

Sincerely,
[Physician's signature]
[Physician's name]

[Suggested enclosures:
Copy of denial letter
Package insert for Doptelet
Medication records
Clinical records that support the need for Doptelet
Other supporting documentation]

NP-38883 12/24