Sample Letter of Appeal for a Denied Prior Authorization

For use with appeals due to a payer policy that has not been updated with the new IZERVAY dosing parameter approved by the FDA on 2/12/2025

This sample letter is for informational purposes only and is not meant to be a substitute in any way for a physician's independent clinical decision-making. There is no requirement that any patient or eye care professional use any Astellas product in exchange for this information. A letter of appeal may be used to appeal a denial from the patient's health plan for coverage for IZERVAY™ (avacincaptad pegol intravitreal solution). This template provides information that may be requested when sending a letter of appeal to a patient's health plan on behalf of a patient being treated with IZERVAY for geographic atrophy (GA) secondary to age-related macular degeneration (AMD) where the denial was based on using IZERVAY for longer than 12 months. Submitting a letter of appeal does not guarantee coverage. It is important to review the specific health plan requirements and each plan's submission process before you use this template. Please refer to the full Prescribing Information when determining whether therapy is medically appropriate for your patient.

Please replace the pink, bracketed content with appropriate details and place the template in your standard practice letterhead.

[Date]
[Health plan name]
ATTN: [Department]
[Medical/Pharmacy director name (if available)]
[Health plan address]
[City, State, ZIP Code]

[Patient's name]
[Patient's plan-specific member ID]
[Patient's date of birth]
[Case number]
[Dates of service]

Re: Letter of Appeal for IZERVAY™ (avacincaptad pegol intravitreal solution)

Dear [Medical/Pharmacy director name],

I, [Eye care professional name], am writing to request that you reconsider your denial of coverage for IZERVAY on behalf of [Patient's name] for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD), associated with the diagnosis code(s) [ICD-10 code(s)].

Based on the denial letter, it is my understanding that coverage for IZERVAY was denied because the request exceeds the 12-month dosing parameter within the medical policy guidelines. [You may state specific reason from health plan's denial letter.]

IZERVAY received an updated label on February 12, 2025 and is now approved for use beyond 12 months. I understand medical policies can take time to update, but with this FDA approval, I feel that IZERVAY continues to be an appropriate therapy for [Patient's name].

Please fax your coverage decision to [Eye care professional fax #] or mail it to [Eye care professional business office address]. Please also send a copy of the coverage determination decision to [Patient name].

If you have any further questions about this matter, please feel free to contact me at [Eye care professional phone number] or via email at [Eye care professional email].

Thank you for your time and consideration. I am looking forward to your timely response.

Sincerely,

[Eye care professional's signature] [Eye care professional name] [Eye care professional NPI] [Name of practice] [Phone #]

Enclosures:

[List and attach additional documents, which may include:

- IZERVAY FDA approval letter – February 2025
- IZERVAY prescribing information – February 2025
- Denial letter from payer
- Letter of medical necessity
- Your clinical notes/medical records]