**Sample Appeal Letter for ARCALYST® (rilonacept)**

***This sample letter is for demonstration purposes only. It provides an example of the type of information that may be required when requesting a formulary exception for ARCALYST from a patient’s insurance company. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence, the independent clinical decision of the prescribing healthcare professional.***

**[Physician or Practice Letterhead]**

**[Date]**

**[Health Plan Name]** Patient: **[Patient’s First and Last Name]**

Attn: **[Department]** Date of Birth: **[Patient’s Date of Birth]**

**[Health Plan Contact]** Member ID #: **[Patient’s Member ID #]**

**[Health Plan Address]** Member Group #: **[Patient’s Group ID #]**

**[Health Plan City, State ZIP]** Claim #: **[Claim #]**

Request: Letter of appeal for ARCALYST® (rilonacept) injection for subcutaneous use

Diagnosis: **[Diagnosis]** (**[ICD-10 code(s)]**)

Dosage: **[Dose and frequency]**

Dear **[Health Plan Contact]**,

I am writing to request reconsideration of your denial of coverage for ARCALYST, which I have prescribed for the patient referenced above.

In brief, the **[diagnosis]** (**[ICD-10 code(s)]**) treatment regimen with ARCALYST is medically appropriate and necessary for **[Patient Name]** and should be covered and reimbursed. ARCALYST was denied for **[Patient Name]** because **[reason(s) for denial]**. Below I have listed relevant information about the patient’s medical history and treatment as well as the clinical rationale for ARCALYST.

**Summary of Patient’s Diagnosis and Medical History**

**[Patient Name]** is **[a/an] [age]**-year-old **[male/female]** patient who has been diagnosed with **[diagnosis]** (**[ICD-10 code(s)]**) as of **[date of diagnosis]**. **[He/She]** has been in my care since **[date]**.

**[Additional information that may be relevant here includes:**

* **Qualitative assessment of the severity of the patient’s pericarditis**
* **Frequency of the recurrence of pericarditis episodes**
* **Pericarditis symptoms experienced by the patient**
* **Impact of pericarditis recurrence on the patient’s health-related quality of life and activities of daily living**
* **Related comorbidities or contraindications (ie, medical history, comorbidities, adverse events, and/or drug interactions) with formulary-preferred agents**
* **Acute and chronic complications associated with the patient’s recurrent pericarditis or complications associated with pericarditis treatment**
* **Previous treatments for pericarditis including drug names, duration of treatment(s), and responses to those treatments (see sample table below)]**

|  |  |  |
| --- | --- | --- |
| **Treatment** | **Start/Stop Dates** | **Responses to Treatment (eg, lack of efficacy, intolerability)** |
| **[Drug name]** | **[MM/YY] – [MM/YY]** | **[Please list reasons]** |
| **[Drug name]** | **[MM/YY] – [MM/YY]** | **[Please list reasons]** |

**Clinical Rationale for ARCALYST® (rilonacept)**

**[Include a summary of reasons the preferred drugs on formulary are not appropriate and why ARCALYST is clinically indicated for the patient based on the Full Prescribing Information and other relevant supporting materials.]**

Considering the patient’s diagnosis, medical history, and the clinical evidence supporting the efficacy of ARCALYSTin treating **[diagnosis]** (**[ICD-10-code(s)]**), I believe treatment with ARCALYST is warranted, appropriate, and medically necessary.

The accompanying materials support my recommendation for ARCALYST for **[Patient Name]**.

I am requesting an expedited review of this request by a board-certified and specialty-matched physician who can render a decision based upon the rationale outlined above. If you have any questions, please contact me at **[physician phone number and/or email]**. I would be pleased to speak to you in more detail about why I consider ARCALYST to be medically necessary for **[Patient Name]**’s treatment of **[diagnosis]** (**[ICD-10-code(s)]**).

I look forward to receiving your timely response.

Sincerely,

**[Physician Name]**

**[Physician signature]**

**[Physician address]**

**[Physician phone number]**

**Enclosures**

**[Include supporting evidence, such as relevant medical records, clinical notes/diagnostic reports, medication records, ARCALYST Prescribing Information, relevant peer-reviewed journal articles, and the FDA Approval Letter for ARCALYST.]**