Submitting an appeal letter

An appeal letter outlines the reasons why a treatment is necessary to meet the medical needs of your patient.

You may want to submit an appeal letter if the payer:

- Denied payment
- Claimed treatment was not medically necessary
- Said the prescription is not covered by your patient's benefits

Depending on the reason for the denial, different materials and additional steps may be required, such as a formulary exception.

For support in person or over the phone, call your Access Specialist at 1.877.COMPLETE (1.877.266.7538).

Please see Indication and Important Safety Information on page 4.
Please see full Prescribing Information at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

Skyrizi™ COMPLETE

Skyrizi™
risankizumab-rzaa
75mg/0.83mL Injection

Sample appeal letter

[Date]

Re: [Patient's name]

[Prior authorization department]

[Plan identification number]

[Name of health plan]

[Date of birth]

[Mailing address]

To whom it may concern:

My name is [HCPs name] and I am a [board-certified medical specialty] [NPI] writing on behalf of my patient, [Patient Name], to request coverage for [product name] [generic]. [Patient Name] has been under my care for [X months] for the treatment of [disease or symptoms].

Make sure you match the language from the denial letter.

We understand that the reason for your denial is [copy reason verbatim from the plan's denial letter]. However, we believe that [product, dosage, frequency] is the appropriate treatment for my patient. In support of our recommendation for [product] treatment, we have provided an overview of my patient's relevant clinical history below.

[Provide a brief medical history, including diagnosis, allergies, existing comorbidities, and International Classification of Diseases (ICD) code(s)].

[Discuss rationale for using product vs other treatments. Insert your recommendation summary here, including your professional opinion of your patient's likely prognosis or disease progression without treatment with product].

[List of pertinent medical records] are enclosed, which offer additional support for the formulary exception request for [product name]. Please consider coverage of [product name] for my patient.

Note here if you are including a letter of medical necessity along with your appeal letter.

Please feel free to contact me, [name], at [telephone number] or [patient's name] at [phone number] for any additional information you may require. We look forward to receiving your timely response and approval of this claim.

Sincerely,

[Physician's name and signature]

[Physician's medical specialty]

[Physician's NPI]

[Physician's practice name]

[Phone #]

[Fax #]

This information is presented for informational purposes only and is not intended to provide reimbursement or legal advice. Providers are encouraged to contact third-party payers for specific information about their coverage policies. For more information, please call an Access Specialist at 1.877.COMPLETE (1.877.266.7538).

Digital version available at CompletePro.com and SkyriziHCP.com.

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For Medicare beneficiaries, there are specific requirements that need to be met for the HCP to be considered a legal representative of the patient in an appeal. For additional information, please visit https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Downloads/Chapter18.zip.

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Writing a sample appeal letter and what to include

Make sure you include all of the information in the letter that is highlighted in red; otherwise, your appeal could be denied

Supplemental documentation may include:

- A copy of your patient's records
- A recent photo(s) of the impacted area(s)
- A summary of your recommendation at the end of the letter
- A letter of medical necessity (LMN)

Appealing a step edit?

If this appeal letter is intended to appeal a plan's step edit therapy requirement, you should consider including the following information in your letter:

This is our **[add level of request]** *coverage authorization appeal. A copy of the most recent denial letter is attached for reference. My patient's medical records are also included in response to the denial.*

[Statement indicating why these step edit therapy requirements are inappropriate for this patient.]

Now that you have submitted the letter with any supporting documentation, the payer must review and decide on coverage within:

72 hours for urgent care

30 days for non-urgent care

60 days for services already provided

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Indication and Important Safety Information for SKYRIZI

Indication[1]

SKYRIZI™ (risankizumab-rzaa) is indicated for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.

Important Safety Information[1]

Infection

SKYRIZI™ (risankizumab-rzaa) may increase the risk of infection. Do not initiate treatment with SKYRIZI in patients with a clinically important active infection until it resolves or is adequately treated.

In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing SKYRIZI. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur. If a patient develops such an infection or is not responding to standard therapy, closely monitor and discontinue SKYRIZI until the infection resolves.

Pre-Treatment Evaluation for Tuberculosis (TB)

Prior to initiating treatment with SKYRIZI, evaluate for TB infection and consider treatment in patients with latent or active TB for whom an adequate course of treatment cannot be confirmed. Monitor patients for signs and symptoms of active TB during and after SKYRIZI treatment. Do not administer SKYRIZI to patients with active TB.

Immunizations

Prior to initiating SKYRIZI, consider completion of all age appropriate immunizations according to current immunization guidelines. Avoid use of live vaccines in patients treated with SKYRIZI.

Adverse Reactions

Most common (≥1%) adverse reactions associated with SKYRIZI include upper respiratory infections, headache, fatigue, injection site reactions, and tinea infections.

Reference: 1. SKYRIZI [package insert]. North Chicago, IL: AbbVie Inc.

Please see full Prescribing Information at https://www.rxabbvie.com/pdf/skyrizi_pi.pdf.

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