LETTER OF APPEAL: PRIOR AUTHORIZATION DENIAL OR CLAIM DENIAL
[To be completed by prescriber and printed on letterhead]

[Date]
[Name of Health Insurance Company]
[Attn:]
[Address]
[City, State, ZIP]

Re: Letter of Appeal for Coverage of QUTENZA® (capsaicin) 8% Topical System

Patient: [Patient Name]
Group/Policy Number: [Number]
Date(s) of service: [Dates]
Diagnosis: [Code and Description]

To Whom It May Concern:

I am writing on behalf of my patient, [Patient Name], to request reconsideration for the coverage of QUTENZA® (capsaicin) 8% topical system that was denied on [date] by [insert name of reviewer] for the following reason: [Describe the reason given in the remittance advice]. [Insert the following sentence if applicable: For your convenience, I have attached the prior authorization request for [Patient Name], which was approved on [date].]

[Patient Name]'s relevant medical history, diagnosis, and treatment plan

- [The patient's diagnosis (ICD-10-CM code), date of diagnosis]
- [The date of the patient's first visit and the date of referral]
- [The severity of the patient's condition]
- [Previous treatment(s), including drug name(s), duration of treatment(s), treatment response(s), and reason(s) for discontinuation]
- [The patient's disease progression, including relevant test results]
- [Additional factors affecting treatment selection]

Justification for medical exception

- [State the clinical rationale for the prescription of QUTENZA]
- [Detail why the plan requirement is not appropriate for the patient]
- [List concerns about the treatment not being approved; these may include your experience with other therapies, drug side effects, and any patient-specific considerations]

[Insert a plan of treatment (e.g., number of systems, duration of treatment, treatment cycle).]

Summary

Given the evidence provided, I am confident you will agree that treatment with QUTENZA is medically necessary for [Patient Name]. It is crucial that [Plan Name] [approve our prior authorization request/allow the use of QUTENZA therapy] so [Patient Name] receives the care [she needs/he needs/they need]. We appreciate your prompt review and reconsideration of this case. Please contact me at [phone number] if you need any additional information.

Sincerely,
[Physician Name]
[Provider Identification Number]

Enclosures: (Attach as appropriate)