[Date]
[Health plan name]

ATTN: [Prior authorization department]
[Contact name (if available)]
[Health plan address]
[City, State, ZIP]

Re: Appeal for Denial of EZALLOR SPRINKLE™ (rosuvastatin) capsules

[Date of birth]
[Insurance ID number]
[Insurance group number]
[Case ID number]
[Date of service]

Dear [Contact name],

This letter is sent on behalf of [patient's name] to request an appeal of a denied prior authorization for Ezallor Sprinkle™. 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 Ezallor Sprinkle™ for the treatment of [x] [ICD-10 code] for [patient's name]. Treatment with Ezallor Sprinkle™ [dose, frequency] is medically appropriate and necessary for this patient.

[Patent's name] is a [age]-year-old [gender] who was diagnosed with [x] 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 Ezallor Sprinkle™ for my patient is based on [provide a clinical rationale for the use of Ezallor Sprinkle™ 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 Ezallor Sprinkle™
Medication records
Clinical records that support the need for Ezallor Sprinkle™
Other supporting documentation

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