PO Box 220262

Charlotte, NC 28211-0262

Phone: **1.877.LIBTAYO** (1.877.542.8296) **Option 1**

Fax: 1.833.853.8362

**LIBTAYOSurround.com**

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**Appeal checklist and sample appeal letter**

If a health plan receives a prior authorization (PA) request and denies coverage for LIBTAYO for your patient, you may appeal the decision. You can use the checklist on page 2 to help ensure you have taken appropriate steps for a successful appeal, and you can use or adapt the appeal letter on page 3 if coverage for LIBTAYO is denied. The sample letter is provided for your guidance only.

Some health plans require an appeal letter along with additional documentation, such as:

* Appeal form, if provided by the plan
* Chart notes
* Test results
* Supporting clinical studies
* Peer-reviewed literature
* Prescribing Information for LIBTAYO

It is important to note that supplying the information for the appeal does not guarantee the health plan will provide reimbursement for LIBTAYO. The information is not intended to substitute for or influence the physician’s independent medical judgment.

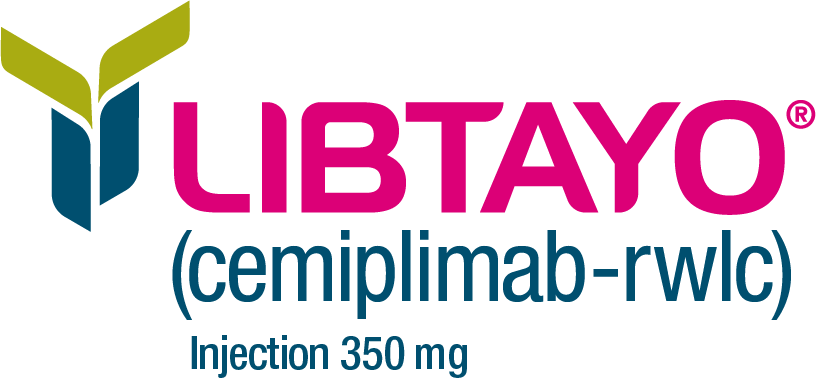
Visit [**LIBTAYOSurround.com**](https://www.libtayohcp.com/libtayo-surround) for more information, including full [Prescribing Information](https://www.regeneron.com/downloads/libtayo_fpi.pdf).

There are numerous reasons why health plans may deny a PA for LIBTAYO. Although the reasons vary by plan, some of the most common include:

* Errors in ICD-10-CM coding on the PA request
* Insufficient documentation on the PA request
* Health plan claims lack of medical necessity for LIBTAYO
* LIBTAYO is not covered by patient’s health plan

Please keep in mind, just as reasons for denial vary, so do each health plan’s requirements for the appeal. It is important to check with the patient’s health plan to ensure you have all the information you need to proceed with the appeal.

ICD-10-CM, *International Classification of Diseases*, *Tenth Revision*, *Clinical Modification*.



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**Appeal checklist**

✔ **Confirm** thatLIBTAYO is covered by the patient’s health plan for the appropriate diagnosis

✔ **Double check** the accuracy of the information provided on the initial PA request

* Patient information
* Coding (it is recommended to use the most specific applicable codes as possible)

✔ **Understand** the reason for the denial—it is often included in the Explanation of Benefits letter

✔ **Review** the plan’s appeal guidelines

* Deadline to submit appeal
* Timeline of review by health plan
* Number of appeals permitted
* Fax number or email address to be used to submit the appeal letter and any additional required information
* Required additional supporting documentation, such as:
* Appeal form, if provided by the plan
* Chart notes
* Test results
* Supporting clinical studies
* Prescribing Information for LIBTAYO

✔ **Clarify** any aspect of the appeal process with the health plan’s review department

✔ **Prepare** a written appeal. The appeal should be written by the physician (see sample letter on next page). In some cases, the patient can write the appeal

✔ **Gather** all required supporting documentation needed to help defend your rationale for coverage for LIBTAYO

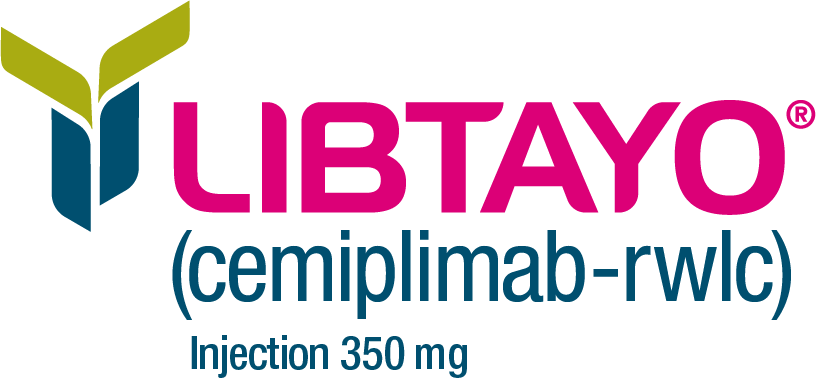
✔ **Send** the written appeal, along with the supporting documentation, to the health plan for review

✔ **Follow up** with the plan on the status of the appeal

✔ **Save copies** of all appeal-related documentation, including:

* Documents submitted with appeal letter
* Documents received from the patient’s health plan
* Health plan representative’s contact information

For any questions or concerns, please contact us at **1.877.LIBTAYO** (1.877.542.8296) **Option 1**, Monday–Friday, 8 am–8 pm Eastern time.



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**Sample appeal letter**

[Use physician’s letterhead]

[Date]

[Health Plan Contact Name]

[Title]

[Health Plan Organization Name]

[Address]

[City, State, ZIP]

Re: [Patient Name], Insurance Policy ID Number: [Policy ID Number], Group Number: [Group Number]

Claim Number: [Claim Number]

Dear [Health Plan Contact Name],

I am writing on behalf of my patient, [Patient full name], to appeal your denial of coverage for LIBTAYO® (cemiplimab-rwlc). It is my understanding that LIBTAYO was denied because [state the specific reason the PA was denied].

I would like to explain why LIBTAYO should be covered for [patient name]. Along with this letter, I am providing information about the patient's medical history and diagnosis (ICD-10-CM code: [insert code]), a statement summarizing my treatment rationale, and other documents that support the medical necessity of LIBTAYO in this clinical case.

[Patient name] was diagnosed with [disease] on [date]. I believe LIBTAYO is needed for the treatment of this patient. The patient’s medical history includes [insert information that summarizes the patient’s treatment history, response to past therapies, recent symptoms and conditions, and opinion of the patient’s prognosis with and without treatment with LIBTAYO.]

Given [patient name]’s clinical condition and the information included in the supporting documentation, I ask you to reconsider your previous decision and to approve coverage for LIBTAYO, which is indicated by the US Food and Drug Administration for this condition.

On behalf of [patient name], I appreciate your reconsideration. If you require additional information, please contact me at [phone number]. Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician’s name, degree(s), and signature]

Enclosures: [Attach any additional documentation, as appropriate]