Suggestions for Writing a Prior Authorization Appeals letter

When a prior authorization (PA) request for UNLOXCYT™ (cosibelimab-ipdl) has been denied, you may submit an appeal letter to support coverage for your patient. Many payers allow multiple levels of appeals for PA denials. Please refer to the plan's specific appeal guidelines for timeframes and submission requirements.

Before preparing your appeal, confirm that UNLOXCYT is covered by the patient's health plan for the appropriate diagnosis. Carefully review the initial PA request for completeness and accuracy—errors and missing information in the initial request are among the most common reasons for denial and can often be resolved by correcting these details in your appeal.

Submit your appeal letter along with a copy of the patient's relevant medical records and a Letter of Medical Necessity (sample available at www.unloxcytpro.com/support).

Checklist

- ☐ **Patient Information**: Include the patient's name, date of birth, insurance policy ID number, and if appropriate, PA denial reference number and date of denial
- ☐ **Denial Acknowledgement**: Confirm that you are familiar with the payer's policy, and state the reason for the denial—it is often included in the Explanation of Benefits letter
- ☐ **Diagnosis Code(s)**: Include specific ICD-10-CM code(s) that align with your patient's diagnosis
- ☐ **Treatment Rationale**: Explain the clinical rationale for treatment with UNLOXCYT and why it is appropriate for your patient
- ☐ **Medical Documentation**: Include copies of relevant medical records:
  - Patient's history, characteristics (eg, age, comorbidities, and ECOG status), diagnosis (including lesion site[s]), disease progression, and prognosis
  - Documentation that the patient is not a candidate for curative surgery or curative radiation
  - Relevant pathology reports, laboratory results, and imaging reports
- ☐ **Treatment History**: List prior therapies, dates they were administered, and the patient's response (or lack thereof)
- ☐ **Formulary Considerations**: Explain why formulary-preferred agents are not appropriate—eg, intolerance, contraindication, or lack of efficacy (if they are not already listed as previous therapies)
- ☐ **Letter of Medical Necessity**: Attach a letter of Medical Necessity (sample available at www.unloxcytpro.com/support)
- ☐ **Supporting Evidence**: Provide evidence such as peer-reviewed literature, clinical trial publications, and the prescribing information for UNLOXCYT, which includes the clinical efficacy and safety profile
- ☐ **Closing Statement**: Summarize your recommendation, and provide a contract number should any additional information be required

ECOG, Eastern Cooperative Oncology Group; ICD-10-CM, *International Classification of Diseases, 10th Revision, Clinical Modification*.

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