SAMPLE LETTER OF APPEAL

(This sample letter is for reference purposes only and is not intended to be a substitute for the independent medical judgment of the prescriber. Use of information in this letter does not guarantee coverage, reimbursement, or payment of any claim.)

[Date]

[Attention, Claims Department Contact]
[Payer]
[Address]
[City, State, Zip Code]

Re: Appeal Request for ILUVIEN® (fluocinolone acetonide intravitreal implant) 0.19 mg for the treatment of diabetic macular edema

[Patient Name]
[Subscriber ID Number]
[Policy Number]
[Group Number]

Dear [Payer contact name],

I am writing on behalf of my patient, [Patient's name], to request reconsideration of a denied claim for ILUVIEN. [Patient's name] received ILUVIEN as an intravitreal injection on [date of service] for the treatment of diabetic macular edema. This letter provides supporting documentation, including information about the patient's history, diagnosis, and my treatment rationale. In addition, I have attached a copy of the product's label information.

Upon review of [Patient's name] history and diagnosis of diabetic macular edema, I can confirm that treatment with ILUVIEN was medically necessary. [Patient's name] was diagnosed with diabetic macular edema on [date], which resulted in [explain impact of symptoms of condition on quality of life, particularly calling out impact on visual acuity]. [If appropriate, describe patient's experience with other medications to treat diabetic macular edema.]

ILUVIEN is an intravitreal implant designed to deliver a sustained amount of fluocinolone acetonide, a synthetic corticosteroid. ILUVIEN is indicated for the treatment of diabetic macular edema in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure. In clinical trials, ILUVIEN has shown to be effective in improving visual acuity.

By treating [Patient's name] with ILUVIEN, [describe expected or realized clinical benefits]. [Describe any past experiences with ILUVIEN, if appropriate.] [Patient's name] is an appropriate candidate for ILUVIEN based on their [describe previous use of corticosteroids] with no significant rise in intraocular pressure.

Based on my assessment, I believe treatment with ILUVIEN was appropriate and medically necessary for this patient. I would appreciate your reconsideration of this claim. Please do not hesitate to contact me directly at [contact phone number] to discuss this case. Thank you in advance for your prompt attention to this matter.

Sincerely,

[Physician name]

Enclosures [Suggested]: ILUVIEN package insert and supportive medical records

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