SAMPLE

*This **sample** LMN/Appeals Letter is provided as a reference only.*

Payers may require different and/or additional information in their LMN or appeals process. Please edit accordingly.

Physicians may want to include additional or different information based on the physician's independent evaluation of the patient.

Date

Insurance Contact
Title
Name of Health Insurance Company
Street Address
City, State, Zip Code

Insured Name:
Policy number:
Claim number:
Date(s) of Service:

Dear Claims Department:

I am writing on behalf of____<***insert patient name***>___ to request coverage and appropriate payment for ADCETRIS® (brentuximab vedotin) for the treatment of ____<***insert complete diagnosis and ICD9/10***>____.

Patient Medical History

___<***insert patient name***>_____ is a ___<***insert age***>____ year old ___***male/female***__ with a diagnosis of ___***insert dx and ICD-9 coding***____. __***She/He***__ has been treated previously with ___***insert previous therapy and duration of therapy***____. ADCETRIS therapy was provided on ___<***insert DOS***>____. ADCETRIS has been granted a permanent HCPCS code, J9042 (injection, brentuximab vedotin 1 mg) effective January 1, 2013.

Medical Necessity

Please find ___<***insert patient's name***> ____ medical history, previous treatments, diagnosis and medical necessity for ADCETRIS therapy. ADCETRIS is medically necessary for ___<***enter patient name>***__ due to ____<***enter clinical rationale, medical necessity and product differentiation***>_____.

We request reconsideration for coverage and payment of ADCETRIS for ___<***enter patient name***>___ for ___<***enter DOS***>___. Please see attached patient chart notes, the ADCETRIS US Prescribing Information and additional pertinent clinical information.

Sincerely,

Physician name
Practice name
Contact Name
Physician and Contact Information (email and phone number)