Sample Letter of Appeal for GAMMAGARD LIQUID®
[Immune Globulin Infusion (Human)] 10% Solution

Please print on office letterhead including provider name and address

[Date]
[Health plan name]
[Department]
ATTN: [Contact title or name]
[Health plan address]
[City, State, ZIP code]

[Patient's name]
[Date of birth]
[Policy number]
[Case ID number]
[Date(s) of service]

Appeal of Denial for GAMMAGARD LIQUID® [Immune Globulin Infusion (Human)] 10% Solution

Dear [Contact name],

I am writing to request reconsideration of your denial of coverage for GAMMAGARD LIQUID, which I have prescribed for [patient's name] for the treatment of [primary immunodeficiency (PI)/chronic inflammatory demyelinating polyneuropathy (CIDP)/multifocal motor neuropathy (MMN)] [insert appropriate ICD-10-CM code here]. Your [reason/reasons] for the denial [is/are] [reason(s) for the denial].

Based on the patient's condition and medical history, as well as my experience treating this patient, I believe treatment with GAMMAGARD LIQUID is medically necessary. Please see my clinical reasoning below.

Patient diagnosis and medical history in support of the appeal

[Patient's name] is [a/an] [age]-year-old [male/female] who has been diagnosed with [PI/CIDP/MMN] as of [date of diagnosis]. [He/She] has been in my care since [date].

[Include relevant medical information to support your reason for treatment with GAMMAGARD LIQUID. Include history of treatment.]

History of previous therapies	Reason(s) for discontinuation of previous therapies	Duration of previous therapies

[Additional information to include:

- Supporting documentation as requested by the plan in their denial letter
- Discussion of clinical attributes of GAMMAGARD LIQUID and relevance to your patient

- Your assessment of why GAMMAGARD LIQUID is appropriate for this patient based on medical evidence]

Summary

In my professional opinion and considering [patient's name]'s history and condition, I believe treatment with GAMMAGARD LIQUID is medically necessary because [insert reason(s) for belief that treatment with GAMMAGARD LIQUID is appropriate]. If you have any further questions about this matter, please contact me at [physician's phone number] or via email at [physician's email]. We look forward to receiving your timely response and approval of this claim.

Sincerely,
[Physician's signature]
[Physician's name]

Enclosures

[List enclosures, which may include:
• Explanation of benefits/denial letter
• Copies of original claim form
• Letter of Medical Necessity
• Clinical notes
• Medication records
• Relevant laboratory reports
• GAMMAGARD LIQUID Prescribing Information
• Other supporting documentation]