CINQAIR® (reslizumab) Injection 100 mg/10 mL | TEVA SUPPORT SOLUTIONS®

Letter of Appeal Template Instructions

A letter of appeal from you to your patient's insurer may be helpful if your patient has received a denial of coverage for CINQAIR®.

The template provided on the reverse side leaves spaces, indicated in red, for the specific information that payers may require, such as:

- The patient's diagnosis, condition, and medical history
- Information about the treatment that was denied
- Information about your patient's medical history and prior treatments
- A summary of your clinical assessment and rationale for requesting coverage
- Other documentation that supports your position

This template is intended only as an example. Teva Support Solutions® recommends confirming individual payers' requirements.

Questions? Call Teva Support Solutions® at 1-844-838-2211.

Please see accompanying full Prescribing Information, including Boxed WARNING for CINQAIR®.

teva | Respiratory

TEVA SUPPORT SOLUTIONS®

[Physician letterhead]

[Medical Director]
[Insurance Company]
[Address Line 1]
[Address Line 2]

Patient: [First and last name]
Patient DOB: [Patient's date of birth]
Policy ID: [Insurance ID #]
Claim #: [If available]

[Date]

Re: CINQAIR® (reslizumab) Injection coverage

Dear [Payer Contact Name, Medical/Pharmacy Director], [Department]:

I am writing this letter to appeal the denial of coverage for CINQAIR® on behalf of my patient, [patient's name], born [date of birth], who has a diagnosis of [insert diagnosis and ICD-10 code]. Your organization cited [insert the reason for denial] as the reason for its denial. Please review the information below that supports use of this medication as approved by the U.S. Food and Drug Administration.

Based on a clinical assessment of my patient, the patient's diagnosis, and medical history, CINQAIR® was prescribed. Below is a brief summary of [patient's name]'s medical history and rationale for treatment with CINQAIR®.

Patient's Medical History and Treatment Rationale:

- Patient's medical history, diagnosis, and current condition (e.g. signs, symptoms, functioning): [Provide a brief statement about the patient's diagnosis and medical history, including any underlying health issues that affect your treatment selection]
- Prior treatments and response to those treatments: [If applicable, provide a list of current and past medications, as well as reasons for not prescribing a medication (e.g., contraindications, drug interactions, lack of efficacy) and a summary of the patient's experience with each medication, including clinical outcome, adverse drug reactions, and length of therapy]
- [Include a summary of why, based on your clinical judgment, your patient requires treatment with CINQAIR®]

In summary, based on my clinical opinion, CINQAIR® is medically necessary and reasonable for [patient's name]'s medical condition. I trust that the information provided, along with my medical recommendations, will establish the medical necessity of coverage for CINQAIR®.

Please contact my office at [office phone number] if I can provide you with any additional information to approve this request.

Sincerely,
[Physician's name]

[Include enclosures as appropriate, such as excerpts from the patient's medical record, relevant treatment guidelines, CINQAIR® Prescribing Information, and relevant clinical data.]