AJOVY®
(fremanezumab-vfrm)
injection 225 mg/1.5 mL

Your guide to preparing an Appeal Letter

If coverage determination is denied by the patient's health plan, an Appeal Letter may be needed.

The appeals process is how plans review medical necessity denials.

Appeal Letters should be submitted along with the patient's medical records and a Letter of Medical Necessity. There can be many levels of appeals, depending on the plan. If you have questions regarding a plan's appeal levels or specific procedures, be sure to refer to that plan's appeal guidelines.

The following sample letter can be helpful for you, the healthcare provider (HCP), and your office staff if it becomes necessary to appeal a coverage determination for a patient's plan. The Appeal Letter covers details often required to process a coverage authorization appeal, including:

- Claim specifics, such as the patient's name, date of denial, claim amount, and group number
- The patient's medical history and course of treatment
- The reason for denial: why the plan was reluctant to provide reimbursement
- All necessary contact information

This guide and the following sample letter are presented for informational purposes only. They are not intended to provide reimbursement or legal advice. When in doubt, you are encouraged to contact third-party payers for specific information on their coverage policies. **Teva recommends confirming the information that is required to include in an Appeal Letter with individual payers.**

INDICATION

AJOVY® (fremanezumab-vfrm) injection is indicated for the preventive treatment of migraine in adults.

IMPORTANT SAFETY INFORMATION

Contraindications: AJOVY is contraindicated in patients with serious hypersensitivity to fremanezumab-vfrm or to any of the excipients. Reactions have included anaphylaxis and angioedema.

Hypersensitivity Reactions: Hypersensitivity reactions, including rash, pruritus, drug hypersensitivity, and urticaria were reported with AJOVY in clinical trials. Most reactions were mild to moderate, but some led to discontinuation or required corticosteroid treatment. Most reactions were reported from within hours to one month after administration. Cases of anaphylaxis and angioedema have been reported in the postmarketing setting. If a hypersensitivity reaction occurs, consider discontinuing AJOVY and institute appropriate therapy.

Adverse Reactions: The most common adverse reactions in clinical trials (≥5% and greater than placebo) were injection site reactions.

Please see the full Prescribing Information for AJOVY.

[<Physician/Practice Letterhead>]

[<Date>]

[<Payer Name>]
RE: Coverage of AJOVY® (fremanezumab-vfrm) Injection
[<Payer Representative>]
[<Payer Address>]
[<City, State ZIP Code>]
[<Payer Fax Number>]

[<Patient Name>]
[<Patient DOB>]
[<Policy Name>]
[<Group Number>]
[<Treatment Date and Claim Number>]
[<Amount of Claim>]

Attention: [<Payer Representative>], [<Claims Department>]

Dear Director of Claims,

I am writing to request a review of a denied claim for my patient, [<Patient Name>]. On [<Date of Denial>], your organization denied this claim for treatment with AJOVY for the following reason(s), which are listed on the attached Explanation of Benefits (EOB):

[Indicate reason(s) for denial from EOB.]

The following is the medical history and course of treatment for [<Patient Name>]:

[Describe the patient's history, diagnosis, previous and current treatment regimens and their outcomes, physical impairment, etc.]

[NOTE: Physicians should exercise medical judgment and discretion in regard to making an appropriate diagnosis and characterization of an individual patient's medical condition. In addition, physicians are responsible for ensuring the accuracy and validity of all billing and claims for appropriate reimbursement.]

I am requesting that you reassess this denial. Treatment with AJOVY is a necessary therapy for this patient's medical condition, and it is my clinical opinion and assessment that [<Patient Name>] is appropriate for treatment with AJOVY.

I trust that the enclosed information, along with my medical recommendations, will establish the medical necessity for payment of this claim. Please contact me at [<Office Phone Number>] if I can provide you with any additional information to approve my request.

Sincerely,

[<Your signature>]

[Enclosures]
[List enclosures as appropriate. Examples of enclosures include: excerpt(s) from patient's medical record, Explanation of Benefits (EOB), relevant treatment guidelines, and product Prescribing Information.]