SAMPLE LETTER OF APPEAL FOR
PRIOR AUTHORIZATION DENIAL FOR
TURALIO® (pexidartinib) capsules

To the prescribing healthcare provider: When determining whether treatment with TURALIO is appropriate for a patient, please refer to the full Prescribing Information, including Boxed WARNING.

IMPORTANT NOTE:
This letter provides an example of the types of information that may be provided when appealing a prior authorization denial from a patient's health plan for TURALIO treatment.

Use of the information in this letter does not guarantee that the health plan will provide reimbursement for TURALIO and is not intended to be a substitute for or an influence on the independent medical judgment of the physician. Please make sure to review the health plan's instructions to determine whether additional enclosures, such as appeal forms, chart notes, test results, and supporting literature, may also be necessary.

KEY REMINDER:
Use this sample letter as a guide to create a letter of appeal on your own physician's letterhead.

[Date]

[Name]
[Insurance Company Name]
[Address]
[City, State, Zip Code]

ATTN: Prior Authorizations/Appeals Department

Re: Coverage of TURALIO® (pexidartinib) capsules
[Patient First and Last Name]
[Insurance Policy Number]
[Insurance Group Number]
[Patient Date of Birth]
Diagnosis: [Diagnosis and Code]

To whom it may concern:

The purpose of this letter is to appeal a prior authorization denial and request your reconsideration of coverage for TURALIO for [Patient Name].

[My office] [My patient] received a notice indicating that [health plan name] has denied this [prior authorization/coverage request] on [date of service] for the following reasons:
[Insert reasons provided in denial letter.]

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[Patient Name]'s medical history and previous and current treatment is consistent with the following:
[Insert description of the patient's medical history as it pertains to treatment with TURALIO. Please include information on functional limitations/symptoms, including diagnosis and test results; all previous and current treatment regimens, including any surgical procedures and treatment outcomes; and patient's likely prognosis without treatment with TURALIO.]

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The information I have provided above justifies the use of TURALIO, [dose/frequency], for [Patient Name], substantiating that it is medically appropriate and necessary. Enclosed is a copy of the full Prescribing Information for TURALIO, which serves to further substantiate the use of TURALIO for this patient.

I ask that you please review the documentation provided and consider reversing your coverage denial of TURALIO for [Patient Name].

I appreciate your prompt attention to this matter and look forward to your reconsideration of this claim. If you need additional information, I am happy to provide it.

Sincerely,
[Physician Name]
[NPI Number]
[Practice Name (if applicable)]
[Address]
[Phone Number]
[Fax Number]