**Instructions:**

This template is offered as a resource a healthcare provider could use when responding to a prior authorization or claim denial from a patient’s health insurance company for Injectafer® (ferric carboxymaltose injection).

When determining if treatment with Injectafer is medically appropriate for a patient, please refer to the full Prescribing Information.

**Use of the letter does not guarantee that the insurance company will provide reimbursement for the medicine requested and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.** Please make sure to include the Prescribing Information and 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. If you need additional references, please contact Daiichi Sankyo Access Central™ at 1-866-4-DSI-NOW (1-866-437-4669).

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

**Sample Letter of Appeal**

Date: [Date]

Payer Name: [Payer Name]

Payer Address: [Payer Address]

City, State, ZIP Code: [City, State, ZIP Code]

Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of Injectafer® (ferric carboxymaltose injection)

Patient Name: [Patient Name]

Patient Date of Birth: [Patient Date of Birth]

Policy Number: [Policy Number]

Group Number: [Number]

To whom it may concern:

I am writing on behalf of my patient, [Patient Name], to appeal [Name of Health Insurance Company]’s decision to deny coverage of Injectafer® (ferric carboxymaltose injection). Injectafer is an iron replacement product indicated for the treatment of iron deficiency anemia in adult and pediatric patients 1 year of age and older who have either intolerance or an unsatisfactory response to oral iron, or adult patients who have non-dialysis dependent chronic kidney disease (NDD-CKD). Injectafer is also indicated for iron deficiency in adult patients with heart failure and New York Heart Association class II/III to improve exercise capacity.

[Patient name] has been diagnosed with [choose 1: iron deficiency anemia or iron deficiency] and [choose 1: is intolerant to oral iron or has had an unsatisfactory response to oral iron or has NDD-CKD or heart failure]. It is my understanding that based on your letter of denial dated [Date] that coverage has been denied for the following reason(s): [List the Specific Reason(s) for the Denial as Stated in the Denial Letter]

**Patient History and Diagnosis**

[Provide a Brief Description of the Patient’s Medical Condition Here.]

[Include a Short Summary of the Patient’s Medical History including documentation of oral iron failure or NDD-CKD.]

[Explain why you believe it is Medically Necessary for Patient to receive Injectafer.]

[Describe the Potential Consequences to the Patient if they do not receive Injectafer.]

[Obtain and Attach Supporting Letters from any other Specialist(s) that is currently providing or has previously provided Care to the Patient.]

The information I have provided above justifies that the use of Injectafer is medically appropriate and necessary for [Patient Name]. The full Prescribing Information for Injectafer is also enclosed, which serves to further substantiate the use of Injectafer for this patient. I request that you please approve coverage of Injectafer for [Patient Name] as recommended. I appreciate your prompt consideration of this matter. If additional information is needed, I am happy to provide it to you.

Sincerely,

[Prescriber’s Name]

[Practice Name]

[Prescriber NPI]

[Practice Address]

[Practice phone number]

[Practice fax number]

References

[Include Injectafer full FDA-Approved Prescribing Information]