

Payers may require prior authorization or supporting documentation to process and cover a claim for the requested therapy. A prior authorization allows the payer to review the reason for the requested therapy and to determine medical appropriateness. A patient-specific letter of medical necessity will help to explain the physician's rationale and clinical decision making in choosing a therapy. The following is a sample letter of medical necessity that can be customized based on your patient's medical history and physical examination. Please note that some payers may have specific forms that must be completed in order to request prior authorization or to document medical necessity.

Please see Full Prescribing Information for KEVEYIS® (dichlorphenamide) at www.KEVEYIS.com/PI.

[Insert letterhead with physician name and address]

Sample Format: Appeal Letter

[Date]
[Payer Name]
[Payer Address]

Attn: [Appeals Department]

Re: [Patient Name]
[Policy ID/Group Number]
[Date of Service]

To Whom It May Concern:

I am writing to request an appeal of the denial for [Patient Name] for treatment with KEVEYIS (dichlorphenamide) 50 mg tablets.

KEVEYIS was approved by the U.S. Food and Drug Administration in August 2015. KEVEYIS is an oral carbonic anhydrase inhibitor that was systematically studied in patients with Primary Periodic Paralysis.

KEVEYIS is the only FDA-approved medication for the treatment of primary hyperkalemic periodic paralysis, hypokalemic periodic paralysis, and related variants.

[Payer Name] has indicated that the reason for the denial was [list the reason(s) for the denial] as per the Denial Letter dated [date of Denial Letter]. I disagree with this decision and request that this denial be reversed.

In my clinical judgement, treatment with KEVEYIS is medically necessary because [list the reason(s) why].

I have enclosed additional documentation that supports treatment of this patient with KEVEYIS. I would appreciate your reconsideration of this decision and ask that you reverse it. If you have further questions, please feel free to call me at [telephone number] to discuss.

Thank you in advance for your immediate attention to this request.

Sincerely,

[Physician Name]

[Enclosures: Full Prescribing Information (additional suggested: include original Prior Authorization Form, Denial/EOB, patient medical history, additional supporting documents)]

KEV-0325 V2 04/2019

SAMPLE