

[Date]
[Health Plan Name]
ATTN: [Department]
[Medical/Pharmacy Director Name (if available)]
[Health Plan Address]
[City, State ZIP]

[Patient's Name]
[Date of Birth]
Patient Policy ID Number: [ID #]
Reference Number: [# if available]
[Dates of Service]

Re: Letter of Appeal for ZEPOSIA® (ozanimod) capsules

Dear [Medical/Pharmacy Director Name],

I am writing on behalf of [patient's name] to request reconsideration of your denial of coverage for ZEPOSIA® (ozanimod), which I have prescribed to my patient for the treatment of [diagnosis], ICD-10-CM diagnosis code [diagnosis code]. Your reason(s) for the denial [is/are] [reason(s) for the denial].

Based on my experience with treating patients with [diagnosis], ICD-10-CM diagnosis code [diagnosis code], and the patient's condition and medical history, I believe treatment with ZEPOSIA is appropriate and medically necessary. This letter provides the clinical rationale and relevant information about the patient's medical history and treatment.

ZEPOSIA is a sphingosine 1-phosphate (S1P) receptor modulator that was approved by the US Food and Drug Administration (FDA) in 2020 for the treatment of adults with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease. In my clinical opinion, ZEPOSIA would be beneficial to the patient.

The patient is [a/an age]-year-old [male/female/other gender identification] who was diagnosed with [diagnosis] on [date]. Below is a rationale for prescribing ZEPOSIA based on my patient's disease summary.

- [Insert disease summary]
- [Supporting information as requested by the plan in their denial letter]
- [Clinical attributes of ZEPOSIA and relevance to the patient]

This is my [level of request] prior authorization appeal. A copy of the [level of denial] denial letter is included along with medical notes in response to the denial. Considering the patient's history and condition, I believe treatment with ZEPOSIA is medically necessary for my patient. Please contact me at [physician's phone number] or via email at [physician's email] should you have questions or need additional information.

Thank you for your time and immediate attention to this request.

Sincerely,

[Provider name, contact information, and signature]

Enclosures: [List and attach additional documents to support your treatment rationale]