AUSTEDO® XR
(deutetrabenazine)
extended-release tablets
AUSTEDO®
(deutetrabenazine) tablets

Appeal Letter Template Instructions

An appeals letter may be helpful to appeal a denial of coverage. The following page is a template letter that healthcare providers can cut and paste onto their office letterhead.

The appeals letter includes the type of information that payers may require to appeal a denial of coverage, such as:

- The patient's diagnosis, condition, and medical history
- Information about the treatment that was denied
- Information about your patient's previous therapies and his/her response to those therapies
- A summary of your clinical assessment, including AIMS score if applicable, and rationale for requesting coverage
- Other documentation that supports your position

Please note that this template is intended only as an example. Teva recommends confirming the information that is required to include in an appeal of a coverage denial with individual payers.

Physician Letterhead

[Insurance Company]
[Address Line 1]
[Address Line 2]

Patient: [Patient's first and last name]
Patient DOB: [Patient's date of birth]
Policy ID: [Insurance ID #]
Policy Group: [Insurance Group #]

[Date]

Re: [select one: AUSTEDO® XR (deutetrabenazine) extended-release tablets/AUSTEDO® (deutetrabenazine) tablets] coverage

Dear: [Payer Contact Name, Medical/Pharmacy Director], [Department]

I am writing this letter to appeal the denial of coverage for [AUSTEDO XR/AUSTEDO] on behalf of my patient, [patient's name], born [date of birth], who [has a diagnosis of Chorea associated with Huntington's disease, G10 Huntington's Disease] or [Tardive Dyskinesia G24.01]. Your organization cited [insert the reason for denial] as the reason for its denial. Please review the information below that supports use of this medication as approved by the U.S. Food and Drug Administration.

Based on a clinical assessment of my patient, the patient's diagnosis, and medical history, [AUSTEDO XR/AUSTEDO] was prescribed. Below is a brief summary of [patient's name] medical history and rationale for treatment with [AUSTEDO XR/AUSTEDO].

Patient's Medical History and Treatment Rationale:

- Patient's medical history, diagnosis, and current condition (e.g. signs, symptoms, functioning): [Provide a brief statement about the patient's diagnosis and medical history, including any underlying health issues that affect your treatment selection, date of diagnosis, and quality of life]
- Prior treatments and response to those treatments: [If applicable, provide a list of current and past medications, as well as reasons for not prescribing a medication (e.g. contraindications, drug interactions, lack of efficacy) and a summary of the patient's experience with each medication, including clinical outcome, adverse drug reactions, and length of therapy]
- [Include a summary why, based on your clinical judgment, your patient requires treatment with AUSTEDO XR/ AUSTEDO]

In summary, based on my clinical opinion, [select one: AUSTEDO XR/AUSTEDO] is medically necessary and reasonable for [patient's name]'s medical condition. I trust that the information provided, along with my medical recommendations, will establish the medical necessity of coverage for [AUSTEDO XR/AUSTEDO].

Please contact my office at [office phone number] if I can provide you with any additional information to approve this request.

Sincerely,
[Physician's name]
[Physician's NPI, TIN, and insurance identifying group number]

Include enclosures as appropriate, such as excerpts from the patient's medical record, relevant treatment guidelines, Prescribing Information for AUSTEDO XR/AUSTEDO, and relevant clinical data.