



***NOTE: This Sample Letter of Appeal is a template to help you write your own letter to health plans. Bracketed copy in blue font color is to be updated, reflecting relevant information for you, your practice, and your patient.***

SCEMBLIX Sample Letter of Appeal

[Date]

[Medical Director’s name]

[Health plan]

[Address]

Re: [Patient’s name]

[Policy number, ID, group number]

[Date of Birth]

Dear [Medical Director's Name/Other],

My name is [HCP's name], and I am a [medical specialty] caring for [Patient's name], who is currently a member of [health plan]. I prescribed SCEMBLIX® (asciminib) tablets for this patient to treat [diagnosis and ICD-10 code] and submitted a [Prior Authorization/Formulary Exception Request/Tiering Exception Request] on [date of submission]. The request was denied on [date of denial and reference number] and the reason given was [reason from the health plan's denial letter]. I request a formal appeal of your denial for SCEMBLIX based onmy review of the patient's diagnosis, care plan, and clinical guidelines for treatment. I maintain that SCEMBLIX is the appropriate therapy for [Patient's name]. The following information supports my recommendation for treatment with SCEMBLIX:

**Summary of Patient's Medical History and Diagnosis**

[***Include a summary of the patient's diagnosis and current condition:*** *Be sure to attach relevant medical records that support this information.*

*The following topics are examples of information you may want to include:*

* Patient's diagnosis and date of diagnosis
* Documentation that other diagnoses have been excluded
* [Disease/condition] test results
* Measurement tool/scale results (if applicable)
* Persistent, troublesome disease/condition aspects or symptoms (if applicable)
* Disease-specific documentation
* Any additional information the provider deems relevant]

**Treatment History**

[***Include a summary of your patient's treatment history:***

* Provide a comprehensive list of previous therapies used, duration of therapy, and reason for discontinuation
* Specify which treatments the patient has tried and failed
* Confirm if the patient has not received adequate results from any previous treatment]

|  |  |  |
| --- | --- | --- |
| Previous therapy | Duration of therapy | Reason fordiscontinuation |
| [BRAND dose, frequency] | [days/weeks/months/years] | [Reason for discontinuation] |
| [BRAND dose, frequency] | [days/weeks/months/years] | [Reason for discontinuation] |

**Rationale for Treatment**

[***Provide your rationale for choosing* SCEMBLIX*:***

* Include clinical support for prescribing SCEMBLIX *(This may be clinical trial data found in the SCEMBLIX Prescribing Information)*
* Detail any of the patient's comorbidities that could serve as contraindications to certain other treatments
* Ensure that you clearly address the health plan's reason(s) for denial. If the plan requires step therapy, provide an explanation indicating why the treatments specified are not appropriate for your patient
* If your patient is already taking SCEMBLIX, describe their response to SCEMBLIX and explain why it is not in the best interest of your patient to switch therapies
* Provide your professional opinion of the patient's likely prognosis or disease progression without treatment with SCEMBLIX]

Given [Patient's name] current condition and treatment history, I believe SCEMBLIX is the most medically appropriate and necessary therapy to treat [diagnosis] for this patient and would appreciate your prompt reconsideration of this denial.

I have included a copy of the denial letter along with relevant medical notes in response to the denial. Please feel free to contact me, [HCP's name, NPI number], by calling [office phone number] to answer any additional questions or to participate in a peer-to-peer review discussing the necessity of SCEMBLIX for this patient. The appeal decision may be faxed to [fax number] or mailed to [HCP business office address]. I look forward to your timely approval.

Sincerely,

[HCP name and signature]

[Specialty, name of practice, phone number]

Encl: Denial letter, Medical records, SCEMBLIX® (asciminib) tablets Prescribing Information



**Novartis Pharmaceuticals Corporation**

One Health Plaza

East Hanover, New Jersey 07936-1080 © 2023 Novartis 11/23 317247