**SAMPLE LETTER TO APPEAL DENIAL OF COVERAGE**

***Please Note: This letter is intended as an example for consideration and may not include all the information necessary to support an appeal of denial of coverage request. Requirements will vary based on the health plan guidelines and patient benefit design. Please note the requesting provider is entirely responsible for ensuring the accuracy, adequacy, medical necessity, and supportability of all information required. Further, the requesting provider is solely responsible for submission to and follow-up with the health plan regarding this appeal. Use of this document does not guarantee coverage or reimbursement and is not intended to be a substitute for or an influence on the independent medical judgment of the physician.***

[PRESCRIBER LETTERHEAD]

***“Prescribing Physician should edit the content of the letter as appropriate for the subject patient***

[Date]  
[Payer name]  
ATTN: APPEALS

[Type in payer name]

[Type in payer address]

**Patient:** [Type in patient’s first and last name]

**Subscriber ID#**: [Type in insurance ID#]  
**Subscriber Group #**: [Type in insurance group#]  
**Re:** Appeal for Denial ofNOURIANZ® (Istradefylline) tablets, for oral use

**Dates of Service:** [Include all denied dates of service]

Dear Appeals Reviewer:

I am writing to formally request an appeal of the above denial for my patient [Patient Name]. According to the denial letter received on [Date of Denial Letter] the reason for denial was [State the Reason Given for Denial].

I respectfully request a review of this decision based on the following grounds:

**Patient’s Clinical History**

[Patient’s name] is a [age] year old [male/female] diagnosed with Parkinson’s disease on [date]. [He/she] has been treated with levodopa/carbidopa for [X] years and has undergone [describe treatment to date]. [**Be sure to include DIAGNOSIS and DATES.**]

Attached to this appeal letter, you will find supporting documents demonstrating the medical necessity of Nourianz as an adjunct treatment for [Patient Name].

**Treatment Rationale**

Nourianz is an adenosine receptor antagonist indicated as adjunctive treatment to levodopa/carbidopa in adult patients with Parkinson’s disease (PD) experiencing “off” episodes. Approved by the FDA on August 27, 2019, Nourianz was validated through four 12-week registrational trials, which showed that patients receiving Nourianz plus levodopa/carbidopa experienced a greater reduction in “off” time compared to those on placebo.

Nourianz is the only adenosine receptor antagonist indicated for the treatment of “off” episodes, offering a valuable non-dopaminergic mechanism of action to address this patient’s medical needs. Given this, I request that [he/she] receive Nourianz for the treatment of [his/her] PD.

In summary, I believe Nourianz is appropriate and medically necessary for [Patient Name], who is experiencing “off” episodes on the current tolerated dose of levodopa/carbidopa. As you know, most available treatment options in PD target the dopaminergic pathway, leaving limited non-dopaminergic options for managing off episodes. Nourianz represents a crucial alternative to treating off time in this patient.

I respectfully request that you review the additional documentation provided and consider your coverage decision regarding Nourianz for [Patient Name]. Thank you for your prompt attention to this matter, and I look forward to your reconsideration. If I can provide any additional information, please contact me at [MD Phone Number] or via email at [Physician Email].

Thank you for your time and consideration.

Sincerely,

[Physician’s name and credentials]

Enclosures

[Relevant clinical/chart notes]

[Prescribing Information]

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