**ROLVEDON™ Sample Letter of Appeal**

[Print on Physician Letterhead]

[Date]

**Attn: Medical Review/Appeals Re:** [Patient Name]

[Insurance Company Name] [Date of Birth]

[Address for Appeals] [Patient Policy Number]

[City, State, Zip] [Claim Number]

[Date(s) of Service]

[Provider: Physician or Hospital]

Request: Appeal request for ROLVEDON™(eflapegrastim-xnst) Injection (13.2 mg/0.6 mL)

Reference Number: [Appeal reference number]

Submission Date: [Date1]

Denial Date: [Date2]

Dear Medical Reviewer,

This letter serves as a request for reconsideration of payment of a denied claim for ROLVEDON(eflapegrastim-xnst) Injection (13.2 mg/0.6 mL), administered to [Patient Name] on [Date(s) of Service].

This patient is under my care for the treatment of [patient diagnosis—insert nonmyeloid diagnosis and myelosuppressive chemotherapy regimen], which increases the patient's risk of infection manifested by febrile neutropenia. You have indicated that ROLVEDON is not covered because [reason for denial].

[Briefly describe patient’s symptoms, therapy to date, and any other pertinent information.]

Treatment with ROLVEDON has been a necessary therapy for this patient’s medical condition, and it is my clinical opinion that [insert statement regarding patient response here, e.g. that [Patient’s Name] has benefited from ROLVEDON].

The attached full prescribing information provides the approved clinical information and FDA indication for ROLVEDON. ROLVEDON has been administered as a medically necessary part of this patient’s treatment.

Please reconsider the coverage decision for the [Date(s) of Service claim(s) for Patient Name].

Please contact me at [Phone Number] if you require additional information.

Sincerely,

[Physician Name]

[Participating Provider Number]

Enclosures [Attach original claim form, denial/Explanation of Benefits, and additional supporting documents (such as patient’s treatment with ROLVEDON, medical history, diagnosis, lab results, and treatment plan).]

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