# Physician Appeal Letter – AMONDYS 45

Insurance Company Name
Insurance Company Address
Insurance Company City, State ZIP
Re: Patient's Name
Type of Insurance
Group/Policy Numbers
Subscriber ID Number

Dear [name of contact person at insurance company],

It is my understanding that [patient's name] has received a denial for AMONDYS 45 because the procedure is [state specific reason for the denial i.e. not medically necessary, experimental, etc.].

As you know, [patient's name] has been under my care since [date] for the treatment of Duchenne muscular dystrophy. [Give a brief medical history emphasizing the most recent events that directly influence your decision to recommend the denied therapy.]

For this reason I am writing to provide you with information regarding AMONDYS 45 [Give a brief, yet specific description of why you believe it should be approved].

I ask that you reconsider your previous decision based on the information above. Should you have any questions, please do not hesitate to call me at [phone number].

Sincerely,
Your Name
Your Street Address, E-mail Address, Phone Number, Fax Number, Cell Phone Number]

Enclosures: Statement of medical necessity if requested