Sample Letter of Appeal

On the following page, you will find a sample Letter of Appeal. This sample letter is intended as an example for healthcare providers who have prescribed BRIXADI™ (buprenorphine) extended-release injection for subcutaneous use CIII and want to appeal to a payer who has denied coverage for a patient.

This letter should be customized by you or your staff to reflect the specific requirement of the payer. Braeburn recommends confirming the information that is required in a Letter of Appeal with individual payers. The sample letter may not include all topics required by a payer. Use of this template or the information in this template does not guarantee reimbursement or coverage. It is not intended to be a substitute for, or to influence the independent clinical judgement of the prescribing healthcare professional.

Please see FULL PRESCRIBING INFORMATION, including BOXED WARNING.

MLR-1059 May 2023

Sample Letter of Appeal

[PHYSICIAN LETTERHEAD]

[Date]

ATTN: [Contact Name/Appeals Dept.]
[Title]
[Name of Health Insurance Company]
[Address]
[City, State, ZIP]

Insured: [Patient Name]
Policy Number: [Number]
Group Number: [Number]
Diagnosis: [Diagnosis and ICD-10 code]

Re: Appeal of Claim denial for BRIXADI™ (buprenorphine) extended-release injection for subcutaneous use CIII

Dear [Contact Name]:

This letter serves as a request for you to reconsider your denial of coverage for my patient, [Patient Name], for treatment with BRIXADI for [his/her] diagnosis of Opioid Use Disorder. Your company has indicated that BRIXADI is not [medically necessary / not covered on the formulary, etc.] because [insert reason for denial from denial letter].

BRIXADI is indicated for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine. BRIXADI should be used as part of a complete treatment plan that includes counseling and psychosocial support.

Patient History and Diagnosis:

- [Patient's diagnosis, date of diagnosis]
- [Brief description of patient's medical condition]
- [Patient's previous and current treatment/therapies]
- [Rationale for treatment]

Considering the patient's medical history and current medical condition, I am requesting that you reassess this denial of coverage. I have determined in my medical judgment that treatment with BRIXADI is a medically necessary part of [Patient Name]'s treatment. I request your prompt re-evaluation of the claim denial [Claim Denial Number] for BRIXADI provided to my patient on [Date of Service].

Thank you for your immediate attention to this request. Please contact me if any additional information is required.

Sincerely,
[Physician Name]
[Physician Practice Name]
[Physician Phone Number]

Attachments: [Original Claim, Denial Letter, Additional Supporting Documents]