**Sample Letter of Coverage Denial Appeal:** This template is intended to be used as a resource. Use of this template or the information in this template does not guarantee reimbursement or coverage. Please note that some payers may have specific forms that must be completed in order to appeal a coverage denial. You can modify the content in this letter as needed based on your medical judgment and discretion, or you can write your own letter.

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**Please see full** [**Prescribing Information**](http://myovant.com/myfembree-prescribing-information.pdf)**, including BOXED WARNING.**

**Please remove this line and all content above before saving.**

Date:

Health Plan Name:

Health Plan Contact Name:

Health Plan Mailing Address:

Patient Name:

Coverage Denial Reference Number:

Prescriber Name:

Prescriber NPI Number:

Prescriber Practice Name:

RE: Coverage Denial [coverage denial reference number] Appeal for [patient first and last name]

To whom it may concern:

I am the overseeing physician for [patient first and last name] and am writing to appeal the coverage denial request for Myfembree® (relugolix, estradiol, and norethindrone acetate) as the required treatment option for [condition/disease]. Based on my background in [prescriber’s specialty] for [number of years], I believe that Myfembree is medically necessary when considering my patient’s clinical history:

* [duration of time patient has been overseen and treated]
* [relevant diagnostic/symptom information]
* [use of previous treatment(s) without desired clinical impact]
* [any additional clinical data that was not included in the original prior authorization submission]

Also, please find attached with this submission, relevant diagnostic information and background for Myfembree:

* [relevant laboratory tests (blood tests, scans)]
* [Myfembree package insert]
* [any other supporting information that is not included in the original prior authorization submission]

Thank you for taking the time to review my coverage denial appeal for [patient’s first name]. If any additional information is required, please contact my office by phone at [1-XXX-XXX-XXXX] or fax at [1-XXX-XXX-XXXX].

Sincerely,

[prescriber name, title]

[medical specialty]

[signature]