COMPOSING A LETTER OF APPEAL

The following information is presented for informational purposes only and is not intended to provide reimbursement or legal advice. Laws, regulations, and policies concerning reimbursement are complex and are updated frequently. While we have made an effort to be current as of the issue date of this document, the information may not be as current or comprehensive when you view it. Providers are encouraged to contact third party payers for specific information on their coverage policies. For more information, please call 1-833-EYEPOINT (1-833-393-7646) and select opt 2.

Recommendations for writing letter of appeal

- The letter of appeal template encourages physicians to ***provide health plans with detailed information*** including patient's medical history, current condition, discussion of unsuccessful attempts at treating the condition and alternative therapies considered.
- It's important to describe ***why the treatment is medically necessary*** and not just state that it is.
- ***Back up your recommendation with medical research*** that YUTIQ® is indicated for the patient's condition.
- ***Refer to past experience*** utilizing YUTIQ and the patient's medical records that indicate they would also be a good candidate for the treatment.

Additional Sources of information to support medical necessity

YUTIQ Prescribing Information

YUTIQ Reimbursement and Diagnosis Code Guide

INDICATIONS AND USAGE

YUTIQ (fluocinolone acetonide intravitreal implant) 0.18 mg is indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

Ocular or Periocular Infections: YUTIQ is contraindicated in patients with active or suspected ocular or periocular infections including most viral disease of the cornea and conjunctiva including active epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, varicella, mycobacterial infections and fungal diseases.

Hypersensitivity: YUTIQ is contraindicated in patients with known hypersensitivity to any components of this product.

WARNINGS AND PRECAUTIONS

Intravitreal Injection-related Effects: Intravitreal injections, including those with YUTIQ, have been associated with endophthalmitis, eye inflammation, increased or decreased intraocular pressure, and choroidal or retinal detachments. Hypotony has been observed within 24 hours of injection and has resolved within 2 weeks. Patients should be monitored following the intravitreal injection

Steroid-related Effects: Use of corticosteroids including YUTIQ may produce posterior subcapsular cataracts, increased intraocular pressure and glaucoma. Use of corticosteroids may enhance the establishment of secondary ocular infections due to bacteria, fungi, or viruses. Corticosteroids are not recommended to be used in patients with a history of ocular herpes simplex because of the potential for reactivation of the viral infection.

Risk of Implant Migration: Patients in whom the posterior capsule of the lens is absent or has a tear are at risk of implant migration into the anterior chamber.

ADVERSE REACTIONS

In controlled studies, the most common adverse reactions reported were cataract development and increases in intraocular pressure.

Please see full Prescribing Information.

[Print on Physician Letterhead]

YUTIQ® Sample Letter of Appeal

Attn: Medical Review/Appeals
[Insurance Company]
[Address for appeals]
[City, State, Zip code]

RE: [Patient Name]
[Date of Birth]
[Policy Number]
[Claim Number]
[Date of Service]
[Provider: Physician or hospital]

Request: Appeal request for YUTIQ® (0.18mg fluocinolone acetonide intravitreal implant)
Reference Number: [Appeal reference number]
Submission Date: [Date1]
Denial Date: [Date2]

[Today's Date]
Dear Medical Reviewer,

We have reviewed and recognize your guidelines for the use of YUTIQ. I am writing on behalf of my patient, [Patient Name], to request you reassess your recent denial of YUTIQ coverage. It is my understanding based on your letter of denial dated [Date2] that YUTIQ has been denied because [Quote the specific reason for the denial stated in the denial letter]. However, we believe that YUTIQ is the appropriate treatment for [Patient's name]. This request is supported by the following information:

Summary of Patient's Medical History

[Patient's name] was diagnosed with [diagnosis] on [date of diagnosis]. This disease has resulted in [briefly describe patient's current medical condition and symptoms, particularly any impact on visual acuity and functional capacity].

Current and Past Treatments

Treatment	Start date	Stop date	Reason for discontinuing
[Identify drug name, strength, dosage form]	[Date started]	[Dates stopped, if applicable]	[Reason for discontinuing]
[Identify drug name, strength, dosage form]	[Date started]	[Dates stopped, if applicable]	[Reason for discontinuing]

Rationale for Reassessment of Denial

YUTIQ (fluocinolone acetonide intravitreal implant) 0.18 mg is indicated for the treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.

By treating [Patient's name] with YUTIQ, I expect [Describe expected clinical benefits and include your professional opinion on the patient's likely prognosis or disease progression without YUTIQ treatment]. [Describe prior successes with YUTIQ, if applicable].

Considering the patient's medical history and current medical condition, I believe treatment with YUTIQ at this time is warranted, appropriate, and medically necessary for this patient. Please call my office at [telephone number] if you require any additional information or documentation. I would appreciate your reconsideration of this claim. Thank you in advance for your prompt consideration of this matter.

Sincerely,
[Physician name]

[Print on Physician Letterhead]

[Provider number]

The following documentation is enclosed:

- YUTIQ full Prescribing Information
- Medical literature regarding the use of YUTIQ for [Diagnosis name; ICD-10 code]
- [Relevant clinical documentation such as history and physical, progress notes, treatment history, and outcomes, if supportive]
- [Applicable coverage policies]
- Letter of Medical Necessity
- Original denial letter