[Physician/Practice Letterhead]

[DATE]

[Payer Name] _____
RE: Adempas® (riociguat) coverage
[Payer Representative] _____
[Payer Address] _____
[City, State ZIP Code] _____
[Payer Fax Number] _____

[<Patient Name>] _____ [<Patient DOB>] _____
[<Policy Name>] _____ [<Group/Policy Number>] _____
[<Treatment Date and Claim Number>] _____
[<Amount of Claim>] _____
Attention: [<Payer Representative>], _____
[<Claims Department>] _____

Attention: [Medical/Pharmacy Director], [Department]

Dear [Medical/Pharmacy Director],

I am the treating [cardiologist/pulmonologist] for [Patient Name, Patient Member ID #], who has been under my care for [X months/years] for the management of [condition], diagnosed according to ICD-10 criteria.

I am writing to formally appeal the denial of coverage for Adempas® (riociguat) for my patient, [Patient Name, Member ID #] dated [Date of Denial]. Your organization denied coverage of Adempas due to the following reasons which are listed on the attached Explanation of Benefits:

[Insert reasons of denial from Explanation of Benefits]

I am requesting you reassess this denial of coverage due to the patient's documented medical necessity and/or history of inadequate response to prior treatment(s):

[Insert detailed description of patient's diagnostic criteria and medical history including previous treatment methods and outcomes]

I am available to discuss this case further and provide any additional clinical information that may assist in your review. Please contact me at [Phone Number] or [Fax Number] to discuss this urgent matter.

Thank you for your prompt attention to this appeal. I look forward to your reconsideration of this coverage decision.

Sincerely,

[PRESCRIBER NAME]
[TITLE]
[NPI NUMBER]
[PHONE]
[FAX]