[Physician's letterhead]
[Date]

[Name of Health Insurance Company]
[PO Box or Street Address]
[City], [State] [Zip Code]

Appeal (or Request for Reconsideration): AKYNZEO® (netupitant/palonosetron) denials

Beneficiary:	[Patient Name]
HIC # or Member #:	[ ]
Dates of Service:	[mm-dd-yy through mm-dd-yy]
Claim #s:	[List each ICN claim number for each date of service denied]

To Whom It May Concern:

The above claims were denied as not medically necessary and not covered. We are requesting a re-determination of the denial of coverage for AKYNZEO®.

[Outline the patient's history, diagnosis, and treatment. Provide rationale for AKYNZEO® treatment.]

In light of the above, I believe AKYNZEO® should be covered for this patient. Use of AKYNZEO® was medically necessary, and it was an appropriate drug for my patient at the time because [state reason]. Relevant documentation is enclosed with this request for re-determination. Also enclosed are copies of claims submitted for payment and explanation(s) of benefits received showing the reason for the original determination(s).

Respectfully Submitted,

[Physician Name, Signature]

Enclosures:
Explanation of benefits
Copies of claim forms submitted (CMS-1500 or CMS-1450)
Copies of patient medical records