[Physician's Letterhead]
[Date]

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

Appeal (or Request for re-determination):
AKYNZEO® (fosnetupitant/palonosetron) for injection 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® fosnetupitant 235 mg/palonosetron 0.25 mg for injection.

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

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

Respectfully submitted,

[Physician Name, Signature]

Enclosures:

- Patient medical records
- Claims forms submitted (CMS-1500 or CMS-1450)
- Explanation of benefits