[Physician’s Letterhead]

[Date]

[Name of Health Insurance Company]

[PO Box or Street Address]

[City], [State] [Zip Code]

Appeal [or Request for re-determination] denials: [**CHOOSE FORMULATION**: AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) injection, liquid solution **OR** AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) for injection, lyophilized powder]

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:

[**CHOOSE FORMULATION**: AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) injection, liquid solution **OR** AKYNZEO® (fosnetupitant 235 mg/palonosetron 0.25 mg) for injection, lyophilized powder].

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

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 to prevent [state complication(s)]. Relevant documentation is enclosed with this request for re-determination.

Respectfully submitted,

[Physician Name, Signature]

Enclosures:

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

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