Instructions:

This appeal letter template is provided as a resource for healthcare providers when responding to an insurance company's denial of coverage of a prescription for ZUSDURI™ (mitomycin) for intravesical solution. Please include the required attachments with the letter of appeal, including insurer forms, Prescribing Information, a copy of the denial or explanation of benefits, and any other additional supporting documents. If you need additional references, please contact UroGen Support at 1-833-UROGEN1 (833-876-4361).

When determining if treatment with ZUSDURI is medically appropriate for a patient, please refer to the full Prescribing Information.

Use of this sample letter does not guarantee that the insurance company will provide reimbursement for the medicine requested and is not intended to be a substitute for or an influence on the independent medical judgment of the healthcare provider.

Sample Letter of Appeal
(Healthcare Provider Letterhead)

Date: [Date]
Payer Name: [Payer Name]
Payer Address: [Payer Address]
City, State, ZIP Code: [City, State, ZIP Code]
Payer Phone and Fax Number: [Payer Phone and Fax Number]

Re: Coverage of ZUSDURI
Patient Name: [Patient Name]
Patient Date of Birth: [Patient Date of Birth]
Policy Number: [Policy Number]
Group Number: [Group Number]

Dear [Name of Medical Director at Health Insurance Company],

I am writing on behalf of my patient, [Name of Patient], to appeal [Name of Health Insurance Company]'s decision to deny coverage of ZUSDURI™ (mitomycin) for intravesical solution, [insert approved indication].

[Patient name] has been diagnosed with low-grade intermediate-risk non-muscle invasive bladder cancer (LG-IR-NMIBC) and has previously received [list all relevant treatments inclusive of therapeutics and/or procedures]. It is my understanding that based on your letter of denial dated [date], coverage has been denied for the following reason(s): [List the specific reason(s) for the denial as stated in the letter of denial].

Information Supporting Appeal Based on Denial Reason

[Provide a brief description of the patient's medical condition here.]
[Include a short summary of the patient's medical history, including documentation of LG-IR-NMIBC diagnosis, duration of use, and reason for discontinuation.]
[Explain why you believe it is medically necessary for the patient to receive ZUSDURI.]
[Describe the potential consequences to the patient if they do not receive ZUSDURI.]
[Obtain and attach supporting letters from any other specialist(s) who is currently providing or has previously provided care to the patient.]
[Include ZUSDURI administration information.]

Thank you in advance for your immediate attention to this appeal.

Sincerely,

[Physician Name]
[Physician Practice]
[Physician Contact Information]

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