**Sample Letter of Appeal:**

**This template is intended to be used as a resource. Use of this template or the information in this template does not guarantee reimbursement or coverage. Please note that some payers may have specific forms that must be completed in order to request prior authorization. You can modify the content in the letter as needed based on your medical judgment and discretion or you can write your own. When you are finished, save the document as a PDF to remove the gray boxes. Please remove all of these instructions before saving.**

[Insert Health Plan Name]

[Insert Health Plan Contact Name]

[Insert Health Plan Mailing Address]

[Insert Patient Name] [Insert Patient Date Of Birth]

[Insert Member ID#] [Insert Member Group Number]

**RE: AUTHORIZATION FOR ORGOVYX**® **(relugolix)**

Dear [Insert Appeal Reviewer or Name of Health Plan Contact],

My name is [Insert Your Name]. I am writing as the treating healthcare provider to appeal the denial of

ORGOVYX tablets on behalf of my patient, [Insert Patient Name], who has [Insert Diagnosis Description].

Please see the enclosed current prescribing information that supports the use of this therapy.

This letter documents the medical necessity for use of ORGOVYX for my patient and provides

information about [Insert Patient Name]’s medical history and treatment, and relevant test results.

My patient needs ORGOVYX because:

[Note: Please use your independent clinical judgment and discretion to populate this section. Please

remove this note before sending.]

[Insert Rationale For TreatmentInsert Lab Values If Available/Applicable]

In conclusion, [Insert Patient Name] has a confirmed diagnosis of [Insert Diagnosis Description]. The goal

of my treatment is [Insert Treatment Goals]. I would appreciate your immediate review of this appeal

and approval of this important therapy.

Thank you for your time, attention, and reconsideration of my request for ORGOVYX treatment for my

patient.

Sincerely,

[Insert Prescriber Name and Date]

[Insert NPI Number]

[Insert Prescriber Contact Information]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)

Attachments:

• [Bullet and list all attachments that are being provided with the form]

**Confidentiality Notice**: This letter contains personally identifiable information and may include individual protected health information (PHI). The information is intended only for use by the individual or entity addressed on this letter. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or the taking of action in reliance on the contents of this letter is strictly prohibited. If you have received this letter in error, please notify the sender immediately so that we can arrange for the return of the original documents to us at no cost to you.