The following is a sample letter of appeal for OJJAARA that should be customized based on your patient's medical history and demographic information. *Please note that some payers may have specific forms that must be completed in order to appeal a denied claim and to document medical necessity.*

[Date]
[Payer Contact]
[Title/Pharmacy Director]
[Payer Company]
[Payer Address]
[City, State, ZIP]

RE: Letter of Appeal for OJJAARA (momelotinib)

Insured: [First and Last Name]
Patient: [If different from insured]
ID/Policy Number: [Insured ID/Policy #]
Group Number: [Insured Group #]
Patient Date of Birth: [Patient Date of Birth]

Dear [Name of Payer Contact / Pharmacy Director]:

Please accept this letter as a formal appeal to the coverage denial recently received by my patient, [Patient Name]. Based on the denial letter dated [Select date], signed by [signatory on denial letter], my patient is being denied coverage for OJJAARA (momelotinib) because [quote the denial reason directly from the denial letter].

From records previously submitted you can verify that [Patient Name] has a diagnosis of [disease] and has previously been treated with [state previous surgeries/treatments]. It is my professional judgment that [Patient Name] will benefit from OJJAARA. Enclosed, please find [medical records/chart notes] that outline [Patient Name]'s medical history in greater detail.
OJJAARA is indicated:

- [for the treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF (post-polycythemia vera and post-essential thrombocythemia), in adults with anemia.]

The prescribing information for OJJAARA is enclosed. As stated, I confirm that [Patient Name] has a diagnosis of [disease] and, in my clinical judgment, warrants treatment with OJJAARA, and that OJJAARA is medically necessary for them as prescribed.

Currently, the treatment plan is to immediately start the patient on OJJAARA, and to treat until disease progression or unacceptable toxicity. [Patient Name] will be treated at [state dosing regimen]. The treatment goal is [state treatment objectives]. In my professional opinion, OJJAARA is medically necessary and is an appropriate drug them currently. Based on this information, [Patient Name] and I, as their treating [state medical specialty, e.g., oncologist], are asking that you reconsider your previous decision and allow coverage for OJJAARA as outlined in this letter. The treatment is scheduled to begin on [Select date].

If you have any further questions regarding this matter, please do not hesitate to call me at [physician telephone number]. Given the urgent nature of this request, I thank you in advance for your prompt attention to this matter.

Sincerely,

[Physician Name, Credentials]
[Physician Signature]
[Provider Identification Number]

Enclosures:
Copies of patient medical records
OJJAARA package insert