

[Physician Letterhead]

[Today's Date]

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

Re: [Patient Name]
Policy Number: [Policy Number]
Group Number: [Group Number]

Dear [contact name on insurance company]:

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 ZEJULA (niraparib) 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 ZEJULA. Enclosed, please find [medical records/chart notes] that outline [Patient Name]'s medical history in greater detail.

ZEJULA is indicated:

- for the maintenance treatment of adult patients with advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to first-line platinum-based chemotherapy.
- for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy.
- for the treatment of adult patients with advanced ovarian, fallopian tube, or primary peritoneal cancer who have been treated with three or more prior chemotherapy regimens and whose cancer is associated with homologous recombination deficiency (HRD) positive status defined by either:
 - a deleterious or suspected deleterious *BRCA* mutation, or
 - genomic instability and who have progressed more than six months after response to the last platinum-based chemotherapy.

Select patients for therapy based on an FDA-approved companion diagnostic for ZEJULA.

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

At this time, the treatment plan is to immediately start the patient on ZEJULA, and to treat until disease progression or unacceptable toxicity. [Patient Name] will be treated according to label at [state dosing regimen]. The treatment goal is [state treatment objectives]. In my professional opinion, ZEJULA is medically necessary and is an appropriate drug for her at this time.

Based on this information, [Patient Name] and I, as her treating [state medical specialty; eg, oncologist], are asking that you reconsider your previous decision and allow coverage for ZEJULA 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
[List enclosures]
ZEJULA package insert