**FOR INFORMATIONAL USE ONLY**: This is a Sample Letter of Appeal. It is not intended to substitute for your medical judgment when providing a diagnosis of the patient’s medical condition or recommendation for a particular treatment. Please transfer this sample letter onto your practice’s letterhead before printing.

[Month day, year]

ATTN: [Medical Director]

[Payer name]

[Payer contact name]

[Payer address]

Re: Letter of Medical Necessity for ROMVIMZA™ (vimseltinib)

Patient: [Patient’s first and last name]

Subscriber ID#: [Insurance ID #]

Group #: [Insurance group #]

|  |  |  |  |
| --- | --- | --- | --- |
| **Reference Number** | **Therapy** | **Submission Date** | **Denial Date** |
| [Reference number] | ROMVIMZA | [Submission date] | [Denial date] |

Dear [Medica/Appeals Reviewer],

I am writing to request [appeal/redetermination/reconsideration] for my patient, [Patient name], for the above-referenced line item(s). I understand from your denial letter dated [month day, year] that ROMVIMZA has been denied because [quote denial reason as communicated in the denial letter].

**Patient Diagnosis**

The case in question involves my patient, [Patient name], who was diagnosed with [ICD 10 code] [diagnosis name] on [month day, year]. As a result of [diagnosis], my patient [enter a brief description of patient history]. Additionally, [Patient name] has tried [state previous surgeries and/or therapies] and [state outcomes].

Please see the enclosed documentation that discusses my patient’s medical history and provides supporting information regarding my request to reconsider treatment for [Patient name] with ROMVIMZA.

**Treatment Information**

ROMVIMZA is a kinase inhibitor indicated for treatment of adult patients with symptomatic tenosynovial giant cell tumor (TGCT) for which surgical resection will potentially cause worsening functional limitation or severe morbidity.

The safety and efficacy profile of ROMVIMZA makes it medically necessary and appropriate for [Patient name], so I ask you to reconsider your denial of coverage. [Include any additional clinical rationale explaining the medical necessity of this treatment.]

**Supporting Documentation**

Please see the enclosed documentation for [Patient name]’s detailed medical history, as well as supporting information for the use of ROMVIMZA for [ICD-10 code] [diagnosis name].

The following items are enclosed [Note: the below items are suggested enclosures and anything not applicable can be deleted]:

* [Package Insert for ROMVIMZA]
* [ICD-10 code, diagnosis name, and dates]
* [Any applicable testing, pathology, and/or imaging results that support TGCT diagnosis and appropriateness of treatment with ROMVIMZA]
* [History of past surgeries, treatments and/or failed treatment(s) outcomes, e.g., pain/steroid medication, Turalio® (pexidartinib), imatinib, Tasigna® (nilotinib)]
* [Applicable coverage policies]
	+ [REMINDER: If the payer has a published policy, include it here]
	+ [REMINDER: If state statute exists, include it here]

Due to the physical impact on my patient from TGCT, I would appreciate your prompt review of this appeal. I am readily available at my office phone number, [Physician’s phone number], to address any questions or concerns you might have regarding this appeal.

Thank you for your time and consideration. Sincerely,

[Physician’s signature]

[Physician’s name and credentials]